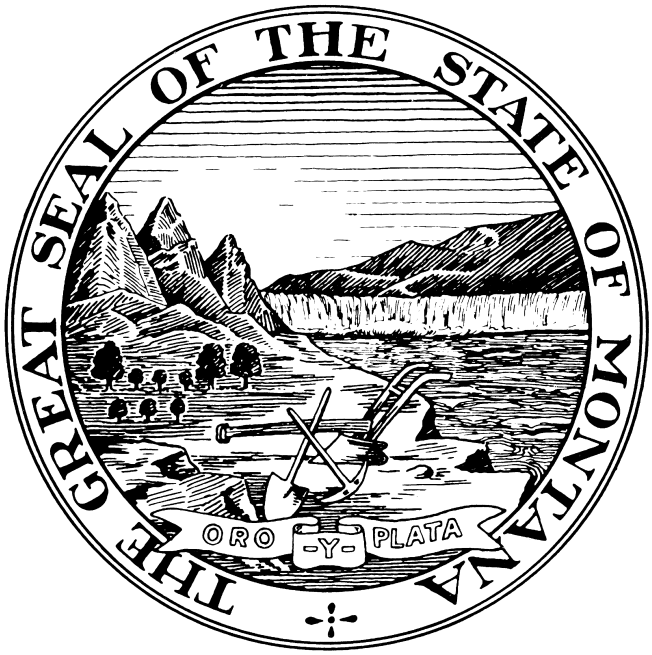
Montana Public Health Care Redesign Project



a report by the
Montana Department of Public Health and Human Services

June 2004

Overview

Part 1 of this report includes:

1. An "Executive Summary," which presents a complete list of the 18 recommendations as endorsed by the Public Health Care Advisory Council with the concurrence of the Department;
2. "Montana's Medicaid Program," which provides general background information about Medicaid and more specifically Montana's Medicaid program; and
3. "The Redesign Process," which describes the organization, chronology, and process followed during the Medicaid Redesign Project.

Part 2 of this report includes a separate section for each of the recommendations and provides more detailed background information on each recommendation as well as the actions that the Department hopes to take to implement the proposal.

Part 3 include the appendices to the report and additional information on specific topics.

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Part 1

Executive Summary

As a result of state revenue shortfalls during the last two legislative sessions (the 57th Legislature in 2001 and the 58th Legislature in 2003), the Department of Public Health and Human Services was forced to make a series of very difficult decisions that resulted in significant reductions in the state's Medicaid program. Given the short time frame of a 90-day legislative session, the complexity of the issues, and the potential for significant harm to recipients through unintended consequences, the Department was determined to avoid similar crisis management in future legislative sessions. To accomplish this, the Department requested legislation to formalize a review of the public health programs administered by the Department. The resulting legislation, HJ 13, directs the Department to conduct a study regarding the health programs administered by the Department and provide a report to the 59th Legislature outlining options that may be undertaken to redesign the health programs administered by the Department. To meet this legislative mandate, the Department has undertaken a comprehensive review of not only the existing eligibility criteria and health benefits provided but also the structure and values that are the fundamental underpinnings of the state's Medicaid system.

> *"There is no question that one of the important issues facing us each day is how government responds to the needs of our most vulnerable citizens."*
>
> Governor
> Judy Martz

An early and important strategic step in the redesign process was the appointment by Governor Martz of a 20-member advisory council to assist the Department. Because this Council represents the general public as well as a broad spectrum of groups directly involved with public health-care programs, it has played a critical role in the development of specific recommendations, served as an informed sounding board to refine proposals presented by the Department, and functioned as a conduit to the different constituencies directly impacted by potential changes to the health-care system. All of the recommendations and actions contained in this report fully incorporate the input of the Council and all have received a formal endorsement by the Council. The contributions and endorsement by the Council are an integral and extremely valuable part of both the redesign process and this final report.

The Medicaid Redesign Project is not intended as a cost-cutting exercise. Rather, the redesign project is intended to reframe Montana's Medicaid program in a fashion that is financially sustainable into the future. The growth dynamics of Medicaid are closely tied to growth in private health-care spending, and individual states cannot control health-care costs on their own. However, strategies that can slow the rate of Medicaid growth by even 2 percent to 3 percent can result in literally millions of dollars in savings. Given that increased costs are inevitable across the entire health-care system, it is anticipated that Medicaid costs will also experience some level of increase. The goal of the redesign is to insure that such increases are reasonable and within budgetary constraints, and that scarce resources are appropriately allocated to most effectively and efficiently meet the health-care needs of Montana's most vulnerable citizens. Although the

redesign is composed of a series of discrete proposals involving major programmatic and administrative changes, it is the synergy of the interrelationship of the collective changes that will ultimately result in real and significant cost containment and a program that is financially sustainable into the future.

The series of recommendations contained in this report do not encompass every unique aspect of the Medicaid program. The Department has deliberately narrowed the focus of the redesign to those areas of greatest concern and to those areas where the Department feels there is a reasonable chance of effecting change in our current economic and political environment. Thus, as with any program, there are areas of the Medicaid program where additional improvements can be made but are not specifically addressed in the present report. However, the collective impact of the recommendations contained in this report do meet the overall objectives of a comprehensive redesign project that will result in greater stability, cost containment and the focus of health-care resources on those most in need. Figure 1 (see page 15) presents a graphical representation of the comprehensive nature of the overall redesign project.

Finally, no recommendation is absolute or final. The history of Medicaid has been one of evolutionary change and it is expected that the recommendations contained in this report will also evolve to meet those changes that invariably occur in terms of shifts in demographics, availability of funds, and advances in medical technology.

The following 18 recommendations and their corresponding actions were developed in close collaboration with the Public Health Care Advisory Council, with significant input from the general public, and countless hours of work by staff of the Department of Public Health and Human Services. The recommendations may be divided into three groups:

a. Recommendations made by the advisory council that have already been fully adopted by the Department and are being integrated into the current operations of the Department. These include recommendations 1 through 4;
b. Recommendations that involve adjustments or refocusing of existing programs and do not require legislation or changes in funding. These include recommendations 5 through 10; and
c. Recommendations that require action by the state Legislature and/or federal government. While the Department can begin the process of developing appropriate legislative language and begin preliminary negotiation with the federal agencies, actual implementation of the recommendations will not occur until after the next legislative session and/or final approval by the federal government. These include recommendations 11 through 18.

Recommendations adopted by the council as defining values and principles for publicly funded health-care programs:

Recommendation #1
Define Fundamental Values, Principles, and Goals

The Council recommended and the Department adopted a set of fundamental values that can serve to focus future consideration of policy changes around certain basic concepts. This set of values incorporates the following concepts:

a. Gives priority to those most in need as defined by the combination of the severity of their economic, social and medical circumstances;
b. Empowers individuals to assume increased responsibility for their health care;
c. Recognizes the differences in populations served by the Medicaid program and the differences in availability of resources in various parts of the state;
d. Insures that quality of care is of primary importance;
e. Recognizes the importance of evidence-based data in any decision making process;
f. Recognizes the importance of effective communication among all parties involved in the Medicaid program, including users, providers, the general public and Legislature; and
g. Recognizes the explicit responsibility of the Department to be publicly accountable for the quality of care provided and the expenditure of public funds.

Recommendation #2
Incorporate Funding Priorities

The Council recommended and the Department has adopted a set of guiding principles and priorities around the relative value of different aspects of the Medicaid program to be applied when budgetary constraints force decisions regarding reductions in Medicaid expenditures. The Council also recommended and the Department has adopted a clear set of procedures that describe the processes to be followed in the event reductions are required.

a. **Client Need:** From inception, the Medicaid program has been designed to serve as the final safety net for those individuals who through economic, social, or medical distress have no other recourse to essential medical care.

   Principle: When considering changes in policy or reduction in services, the Department and Legislature should first protect those most vulnerable and most in need as defined by the combination of the severity of their economic, social and medical circumstances.

b. **Quality of Care:** The Medicaid program must maintain acceptable standards of quality of care.

   Principle: When considering changes in policy or reduction in services, preference should be given to elimination of an entire program or service rather than sacrifice the quality of care for several programs or services through dilution of funding.

c. **Quality of Life:** The Medicaid program supports and funds the definition of *Health* as a state of complete physical, mental and social well-being and not merely the absence of

disease or infirmity. Thus, Medicaid provides services beyond those necessary to protect life or prevent severe injury.

Principle: When considering changes in policy or reduction in services, priority should be given to retaining those services that protect life, alleviate severe pain and prevent significant disability.

Recommendation #3
Implement Management Principles and Data

The Council recognized the critical importance of sound management to the effective administration of the Medicaid program. Given the amount of public dollars spent in the program and the impact policy changes have to the health and welfare of so many Montana citizens, it is imperative that the Department have the resources and processes in place to provide accurate and timely reports to the public on both fiscal and clinical operations of the Medicaid program. Important policy decisions must be based upon data that are not only accurate but also sufficient to reasonably predict the consequences of those decisions. The Council recommended and the Department has adopted a set of management principles that incorporate the following features:

a. Implement a common set of fiscal management principles and expectations across all Department divisions involved in the administration of the Medicaid program;
b. Develop a new Medicaid Management Information System (MMIS) that includes an enhanced Decision Support System (DSS) to provide more accurate and comprehensive management information and to expedite electronic provider billing and reimbursement; and
c. Work with tribes to foster a spirit of cooperation and identify current institutional barriers limiting the participation of tribal members in the Medicaid program and develop strategies, including education, to improve the mechanics of providing Medicaid services to Native Americans by;
    i. Insuring tribes have an adequate opportunity to review and verify data used to monitor Medicaid services and eligibility status, and data used to modify or promote changes in Medicaid policy;
    ii. Consulting with tribal representatives on the effective use and appropriate sources of information on Native American health-care needs;
    iii. At the request of tribal representatives, conducting technical assistance workshops to address issues specific to tribal needs regarding such matters as centralized billing procedures, sound health-care business practices, development of needed health-care infrastructure; and
    iv. In compliance with requirements of HB 608, consulting with tribes on any policy changes that may impact services or programs operated by the tribes.

Recommendation #4
Establish Reimbursement Principles

The Council strongly recommended and the Department agreed it should develop the data and processes necessary for policymakers to make informed decisions regarding adjustments

to reimbursement levels in a manner that is objective, publicly verifiable, and equitable to all provider groups. Such data systems and processes must include the following:

a. Develop a set of data requirements and processes that can be used to objectively quantify the adequacy of all Medicaid provider reimbursement rates including comparison with reimbursement rates outside the Medicaid program;
b. Conduct a cost-of-care analysis of services highly dependent on Medicaid reimbursement;
c. Conduct an analysis of existing reimbursement rates using the data and processes described above;
d. Develop a series of principles that can be applied when considering any reimbursement rate increases to insure equity among providers and to minimize service distortion; and
e. Reject across-the-board solutions regarding reductions in reimbursement rates.

The Council further recommended that the Department engage CMS and Congress to support efforts to have all services for eligible Native Americans included in the State Medicaid Plan be eligible for 100 percent FMAP regardless of the location where services are provided.

Council recommendations requiring adjustments (potentially rule or statute changes) to existing programs:

Recommendation #5
Maximize Medicaid Third-party Liability

The Council recognized the critical importance of insuring that the Medicaid program aggressively recovers all funds that are appropriately due from legitimate third-party liability and estates. To accomplish this, the Council recommended that the Department aggressively pursue maximization of Third-party Liability (TPL) recoveries for Medicaid. The Department should adopt a series of policies to maximize recovery through opportunities associated with:

a. Lien and Estate Recovery;
b. Third-party Insurance;
c. Trauma-Related Insurance and Settlement (i.e., car accidents, etc.);
d. Workers' Compensation;
e. Health Insurance Premium Payments (HIPPS) when cost-effective;
f. Buy-in of Medicare Coverage for those eligible;
g. Recoupment of Medicaid costs through third-party assets when possible;
h. Maximizing TPL capabilities during development of the new Health Care Eligibility System (HCES).

Recommendation #6
Implement a Medicaid Eligibility Field Review

The Council recommended and the Department agreed to develop and implement a Medicaid Eligibility Field Review process in order to ensure access to Medicaid services and that all Medicaid eligibility determination decisions are consistent with the eligibility processes and

standards established by the state and federal governments. The Council also recommended and the Department agreed to develop a policy and process to review all eligibility issues as they relate to Medicaid eligibility.

Recommendation #7
Community Health Center Demonstration Project

Due to a number of unanswered questions and the fact that many of the Community Health Centers are relatively new to their communities, the Council and Department agreed that it is premature for the Department to pursue two proposed demonstration projects as originally conceived. However, the Council and Department concurred that the Community Health Center network does represent a potential resource for the Medicaid program and the Department should establish a mechanism, such as an ongoing work group, to identify opportunities for innovative use of the CHC network.

Recommendation #8
Develop a Strategic Plan for Adult Mental Health Services

The Council recommended and the Department agreed to aggressively pursue the implementation of an enhanced service delivery system for adults with mental illness and chemical dependency that reflects the following components:

a. Develop at least three Service Area Authorities to work in partnership with the Department in the planning and delivery of mental health and chemical dependency services;
b. Review the mission, utilization and admission practices of state operated facility-based services provided by the Montana State Hospital, Montana Chemical Dependency Center, and Montana Mental Health Nursing Care Center;
c. Develop a written strategic plan to implement a system of facility-based care that is appropriate to need, focuses on rehabilitation and treatment, and provides a clear definition of the role and complementary purpose of each facility in the context of the larger community-based system of care;
d. Develop a system of community services that addresses both crisis stabilization and a full range of recovery-based services;
e. Encourage employment of culturally sensitive and appropriately trained mental health providers to provide services to Native Americans living on reservations or in urban areas with significant numbers of Native American peoples;
f. Develop procedures that emphasize and adequately reimburse those providers that deliver demonstrated evidence-based services; and
g. Develop a service delivery system that is capable of meeting the needs of adults with severe and disabling mental illness while containing costs within the levels appropriated by the Legislature.

Recommendation #9
Develop a Long-term Care Education Program

The Council recommended and the Department agreed to develop and implement a continuing public education campaign to inform Montanans about long-term care issues and options. Such a program should be developed in collaboration with other agencies involved with long-term care issues. The program should include the following components:

a. The Senior and Long Term Care Division should assume the lead role in the development of the program and coordination with other appropriate agencies;
b. The information provided should emphasize the need for individual long-term care planning and assumption of personal responsibility for individual health-care needs;
c. A description of the options available for long-term care insurance should be provided including changes in the Medicaid program such as the Long Term Care Insurance Partnership Program; and
d. Information should be provided about current Medicaid regulations regarding transfer of assets and the consequences of inappropriate transfer in anticipation of receiving Medicaid benefits.

Recommendation #10
Participate in a Health Education Program

The Council recommended and the Department agreed that, in collaboration with other health-care agencies, the public school system, and various low-income and advocacy groups, the Department should work to develop an appropriate health education program that would include the following characteristics:

a. General education that can be provided in K-12, emphasizing health and nutrition, life skills including appropriate access of the health-care system, health-care finances, nutrition and the consequences of lifestyle choices, and physical education for all ages;
b. Education for specific disease management programs that targets individuals diagnosed or at high risk. Develop, actively provide, and measure the effects of implemented disease management programs;
c. An education program available at multiple access points including middle school and high school, eligibility offices for new Medicaid recipients, hospital emergency rooms, follow-up care situations, doctor's offices;
d. Information widely dispersed and easily accessible using a variety of public and private media; and
e. An education program that is age, culturally, and access-point appropriate.

The public health education program should be developed in conjunction with Recommendation #9, Development of a Long Term Care Education Campaign.

Council recommendations requiring a combination of state rule/statute changes and/or funding changes and potentially waivers of federal regulations:

Recommendation #11
Improve Services for Seriously Emotionally Disturbed Children

While acknowledging that a change in service delivery for seriously emotionally disturbed children (SED) as complex as envisioned under the Department's proposal will continue to evolve, the Council recommended and the Department agreed to develop a network of service delivery for seriously emotionally disturbed children that emphasizes direct support for children and their families, provides significantly enhanced flexibility of services, and contains expenditures within reasonable and predictable limits. Such a new system should potentially incorporate the following major components:

a. A 1915(c) Home and Community Based Waiver to allow enhanced flexibility of services within the context of directly supporting children and families with the goal of maintaining children in their families and communities;
b. Involvement of local Kids Management Authorities (KMA) in development and administration of the system;
c. Encouragement of employment of culturally sensitive and appropriately trained mental health providers to provide services to Native Americans living on reservations or in urban areas with significant numbers of Native American peoples;
d. Integration of the legislatively adopted system of care concepts; and
e. Provision for enhanced accountability through third-party clinical evaluations of recipients and periodic third-party evaluation of provider performance based upon specific outcome criteria.

Recommendation #12
Submit a Health Insurance Flexibility and Accountability Waiver

The Council recommended and the Department agreed to pursue a Health Insurance Flexibility and Accountability (HIFA) Waiver that incorporates the following major components and submit the waiver proposal to the 59th Montana Legislature for its consideration and approval. Pending legislative approval, the Council further recommended that the Department immediately initiate preliminary discussions with the appropriate federal agency to define the broad parameters of issues regarding cost neutrality, federal caps, service limitations, and service delivery systems. The HIFA Waiver should include the following components:

a. Provide Medicaid funding for current mental health and pharmacy services, as well as a new basic primary-care benefit, to Mental Health Services Plan (MHSP) recipients;
b. Provide health-care coverage to some members of the following groups of uninsured Montanans, balancing the need to provide levels of coverage that are adequate with the desire to insure as many people as possible:
    i. Children with a serious emotional disturbance who are leaving the children's mental health services system and may experience difficulty

transitioning to the adult mental-health services system;
ii. Children eligible for the CHIP health-care program; and
iii. Low-income working parents of Medicaid and CHIP children.

c. Allocate a portion of the Mental Health Block Grant to fund Service Area Authorities and further development of the adult mental health system of care;
d. Provide one-time funding to enhance the Medicaid Management Information System (MMIS);
e. Explore the feasibility of providing CHIP participants and Medicaid/CHIP parents with the various options such as enrollment in an employer premium assistance program, managing a self-directed health insurance account, or remaining in their existing benefit program;
f. Require some form of enhanced cost sharing for HIFA Waiver participants, including MHSP, based on their ability to pay; and
g. Maintain total general fund expenditures at the amount appropriated to MHSP in FY2004.

Recommendation #13
Initiate Changes in Medicaid Eligibility

The Council reviewed and recommended a number of changes in Medicaid eligibility that are also supported by the Department. In addition, the Council reviewed and in concurrence with the Department specifically rejected a number of options for changes in Medicaid eligibility. The recommended changes are:

a. The Department should develop the necessary state regulation and federal requirements to extend the look-back period for asset transfer from the current 36 months to a look-back period of 60 months;
b. The Department should develop the necessary state regulation and federal requirements to begin the Asset Transfer Penalty Period in the month of Medicaid application;
c. The Department should develop the necessary state regulation and statutes to implement appropriate restrictions on Medicaid eligibility for adults who fail to cooperate with their TANF agreements. The Council does not recommend, nor the Department support, any sanction or restriction on Medicaid benefits for children;
d. The Department should develop the necessary state regulation to allow the Department to close Medicaid cases immediately after the 10-day written notice of termination requirement is met;
e. The Department should develop the necessary state regulation and federal requirements to develop a Long Term Care Insurance Partnership program using the "Dollar for Dollar" model;
f. The Department should develop the necessary state regulation and federal requirements to retain the Waiver of Deeming of parental assets and income for families with children with disabilities and require some form of enhanced cost sharing based on ability to pay for families who become eligible for Medicaid under Waiver of Deeming criteria; and

g. The Department should explore the feasibility of a demonstration waiver to delegate authority to eligible tribes for certification of Medicaid eligibility.

Recommendation #14
Seek Tribal Exemption

The Council recommended and the Department agreed that—when possible, necessary, and appropriate under state and federal law or regulation—the Department should seek exemption for Indian Health Services and tribal facilities from changes in eligibility categories, eligible services, and reimbursement levels under the Montana Medicaid program that could potentially result in a direct shift of costs from the 100 percent federal Medicaid reimbursement to direct costs to either Indian Health Services or tribally sponsored health-care services.

Recommendation #15
Implement Pharmacy Cost Containment

The Council recommended and the Department agreed to continue to explore, and when appropriate implement, new and effective mechanisms to contain the rapidly escalating expenditures for Medicaid prescription drugs, including actions such as adopting a Preferred Drug List and/or seeking a federal waiver to require higher co-payments for equally effective, but higher cost, drugs. The Council further recommended and the Department agreed to explore the feasibility of developing a state drug discount program, examining the potential for re-importation of drugs from other countries, and examining the potential of developing an evidence-based drug program to work in coordination with the Preferred Drug List.

The Council further recommended and the Department agreed that, at the request of IHS or the tribes, the Department should seek mechanisms, including, if necessary, a 1915(b) Freedom of Choice Waiver, to insure that IHS-eligible Medicaid participants on reservations have their prescriptions filled at IHS or tribal facilities.

Recommendation #16
Explore Family-planning Waiver

The Council recommended and the Department agreed to explore the feasibility of submitting a Section 1115 Waiver for the purpose of expanding family-planning services. The primary goal of the Montana family-planning demonstration project would be to reduce Medicaid costs by decreasing unintended pregnancies and births to women who potentially may become Medicaid recipients through pregnancy-related eligibility criteria. These costs include prenatal care, delivery, and medical costs for the mother, and ongoing health care for the child.

Recommendation #17
Develop Transportation Brokerage System

The Council recommended and the Department agreed to review the feasibility of implementing a pilot transportation brokerage program for a selected region of the state. Based on the results of the review, the Department could implement a transportation brokerage project in selected areas of the state. In addition to cost factors, the Department should also assess the quality of transportation services, timeliness of services, and increases in access to services.

Recommendation #18
Seek Codifying Legislation

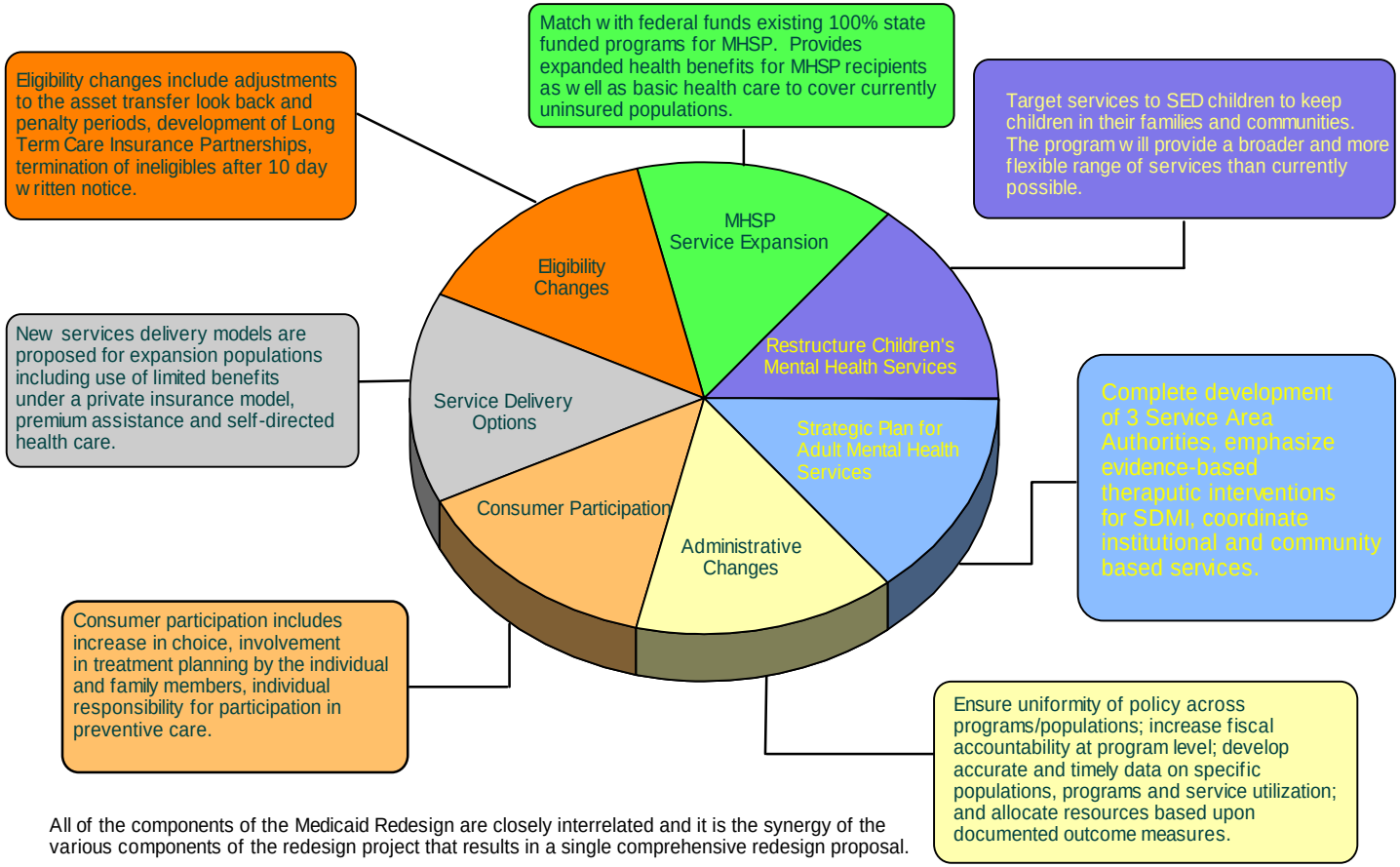
Recognizing the need to formally establish continuity in policy development and management procedures employed by the Department and Legislature, the Council recommended and the Department agreed that the Department should seek an amendment to a section of Title 53, Chapter 6, MCA, during the 59th legislative session that will incorporate the following as fundamental core values and principles of the Montana Medicaid program:

a. When considering changes in policy or reduction in services, the Department and Legislature should first protect those most vulnerable and most in need as defined by the combination of the severity of their economic, social and medical circumstances.
b. When considering changes in policy or reduction in services, preference should be given to elimination of an entire Medicaid program or service rather than sacrifice the quality of care for several programs or services through dilution of funding.
c. When considering changes in policy or reduction in services, priority should be given to retaining those services that protect life, alleviate severe pain and prevent significant disability.

Additionally, the Council recommended and the Department agreed that the Department should seek an amendment to MCA 53-6-110 (Report and Recommendations on Medicaid Funding), requiring the Department to include in its biennial report to the Legislature a chapter that provides specific reference to the Council's recommendations as included in the final report of the Medicaid Redesign Project. Future changes to the recommendations specifically related to administrative policies and procedures, including third-party liability issues, would be maintained and updated through the Medicaid Advisory Council established under federal CFR 42 and reported as a required component of the Department's biennial report to the Legislature.

Figure 1

Montana's Comprehensive Medicaid Redesign



All of the components of the Medicaid Redesign are closely interrelated and it is the synergy of the various components of the redesign project that results in a single comprehensive redesign proposal.

Background Information on Montana's Medicaid Program

In 1966 when President Lyndon Johnson launched his "War On Poverty," a major cornerstone of his overall plan was to provide basic health care for the nation's elderly and poor. **Medicare** was designed to assist the elderly and **Medicaid** was created to provide coverage for the poor. While Medicare is predominantly a federally administered and funded program, Medicaid is a shared responsibility between the federal government and individual states. As is true with many such new programs, these programs were adopted with an incomplete understanding of their potential for future growth, complexity, and financial cost. Original cost estimates were less than $1 billion for the first year and projections included in the original legislation claimed that expenditures would never exceed more than $10 billion annually. In fact, by 1971 Medicaid expenditures had already grown to $6.5 billion and by 1980 had reached $25 billion. However, the annual rate of grow really began to accelerate during the mid-1980s. By 1995, total expenditures exceeded $152 billion. Between 1999 and 2003, Medicaid expenditures grew 60 percent from $166 billion in 1999 to over $265 billion in 2003.

Although originally designed as an optional federal/state partnership (no state is required by law to participate) every state has joined the Medicaid program. Medicaid has now become an imbedded and a financially critical component of every state's health-care system. In addition to its primary purpose of providing health care, Medicaid has a significant role in creating new jobs, supporting hospitals and rural health-care clinics, and training new health-care professionals. It is inconceivable that any state could now afford to withdraw from the program. Unfortunately, because Medicaid was designed as an entitlement program with certain federally mandated eligibility requirements and federally mandated medical services, states have limited control over the significantly increasing costs of the program. As a result, despite some very innovative programs initiated by the states to control the growth of the program, Medicaid has become the 800-pound gorilla in virtually every state's budget. With the possible exception of K-12 education, Medicaid is generally the single largest item in states' budgets today.

> "*…increased Medicaid spending makes it difficult, if not impossible, to increase funding for other priorities, such as education, law enforcement, transportation, and other social services.*"
>
> National Governors Association

Because Medicaid is a state/federal partnership that allows individual states some flexibility in the design of eligibility standards and the provision of "optional" services, there is considerable variation among the state Medicaid programs in terms of recipient access, the scope of the health benefits package, administrative structure, reporting requirements, provider participation, the degree to which managed care is emphasized, and the organizing goals and philosophy (or lack thereof) that guide them. Compounding this problem is the constant tinkering with Medicaid statutes and regulations by Congress and the U.S. Department of Health and Human Services. OBRA, COBRA, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the Balanced Budget Act of 1997, and the various waiver programs have all contributed to the increasing administrative complexity of the program

and the divergence of providers, state staff and resources away from direct health-care services to administrative functions. Over the years, most state Medicaid programs have evolved into a patchwork of different sub-programs reacting to changing federal regulations and lacking a consistent theme or set of clearly articulated overarching goals.

Finally, the Medicaid program has become a very important political issue for health-care providers, advocacy groups, cash-strapped legislatures, and the executive branch of government. As the amount of funding for Medicaid has increased, there has been a correlative increase in the dependence on the program by various special-interest groups. Most attempts to reform Medicaid to better meet the needs of clients and the changing health-care environment are generally portrayed to the public as a callous disregard for the needs of the state's most vulnerable populations. As a result, with a few notable exceptions, states have shied away from major health-care reform.

Montana Medicaid: By and large, Montana has followed the national trends in the evolution of its Medicaid program. Starting with the core mandatory eligibility groups and health-care services, over the years Montana has added additional "optional" eligibility groups and "optional" benefits to the extent that Montana currently offers nearly all of the optional services allowed under the program. Although straight comparisons among Medicaid programs are difficult, Montana probably ranks somewhere at the low end relative to eligibility for services but toward the very high end in terms of the range of benefits allowed.

Under current federal regulations, there are 28 mandatory eligibility groups and 21 optional eligibility groups that can qualify for federal matching funds. While Montana's Medicaid program includes most optional eligibility groups, the actual eligibility criteria (income and assets) are fairly restrictive. Broadly, Medicaid eligibility is divided into three groups: 1) categorically needy, 2) medically needy, and 3) special groups. Determination of eligibility within each of those groups is a combination of factors: social (family status); physical (aged, blind or disabled); and economic (income and assets).

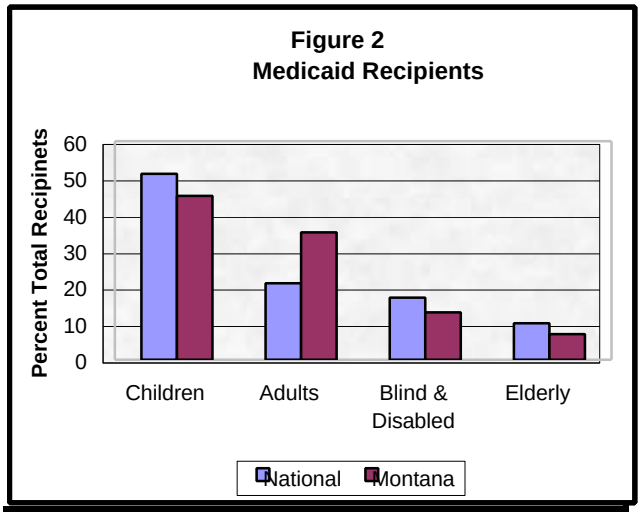
> *"Medicaid is a critical safety net providing essential health care to thousands of low-income Montana citizens."*
>
> John Chappuis, State Medicaid Director

Like all states, Montana is required to provide the 12 mandatory health-care services to all categorically eligible recipients. Montana also provides 33 of the 38 optional services allowed under the Medicaid program to all eligibility groups the state covers. Only three other states provide more optional benefits than Montana. Most states provide fewer optional services, and some states restrict provision of optional services to just the categorically eligible.

Figures 2 and 3 compare Montana's Medicaid population and expenditures with national Medicaid data. As Figure 2 indicates, the distribution of Montana's Medicaid population generally parallels the national distribution viz., more children than adults and more children and adults than the blind, disabled and elderly. However, Montana has proportionately fewer children than the national average and significantly more adults. Also, the relatively

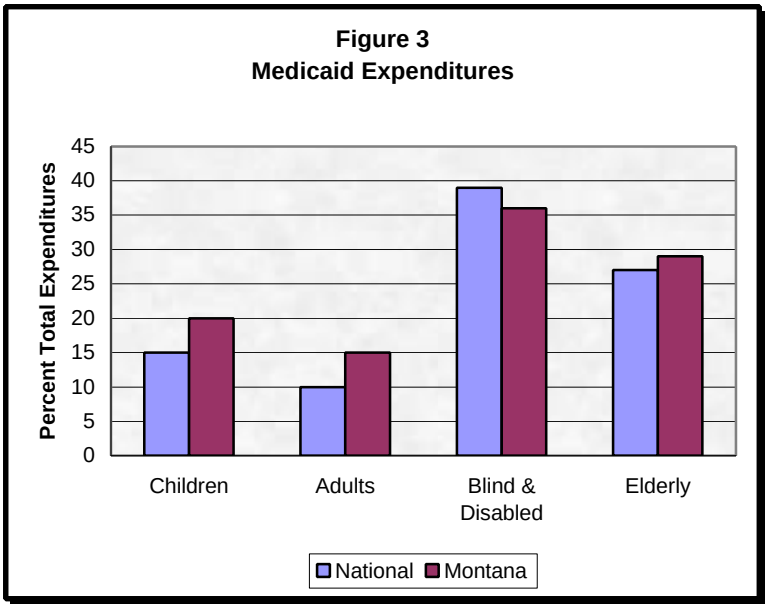
smaller proportion of elderly Medicaid recipients in Montana is curious because, based on census data, Montana has an older population than the national average. These differences in the distribution of Montana's Medicaid population have significant program and financial implications for the overall Medicaid program. As may be seen in Figure 3, the cost to the Medicaid program for children and adults is significantly less than the costs for the elderly and disabled. On the national level, the average annualized Medicaid cost per child is $1,225 versus $1,889 per adult, $9,558 for the blind and disabled and $11,235 per elderly enrollee in 1998.

Figure 2
Medicaid Recipients



The comparable figures for Montana are $1,462 per child, $1,373 per adult, $9,650 for blind and disabled enrollees, and $13,735 for the elderly. Thus, expanding services or eligibility to children or adults would have a significantly lower impact on the costs of the Medicaid program than if services or eligibility were expanded for the blind, disabled, or elderly. The converse is also true, small adjustments to the eligibility or services to the blind, disabled or elderly can result in substantial savings.

Figure 3
Medicaid Expenditures



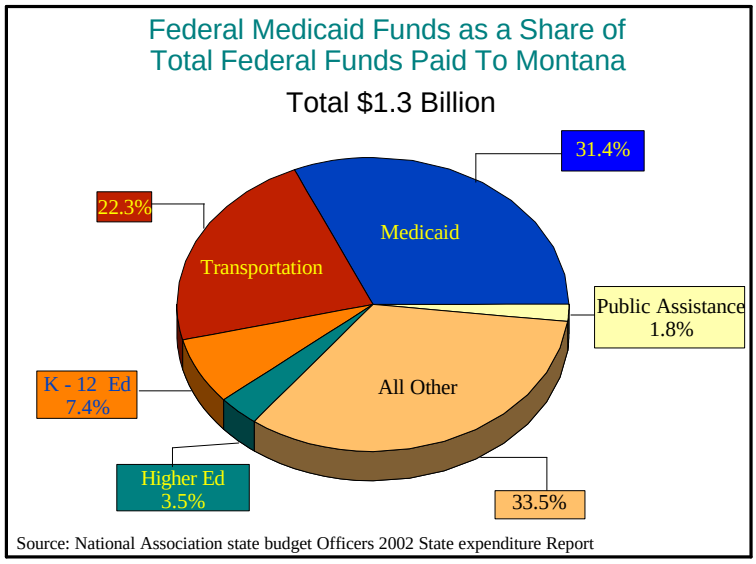
A comparison of Figures 2 and 3 also indicates a consequence of the policy decisions made by the Department and Legislature over the years. With the exception of adults, Montana provides services to fewer people than the national average. On the other hand, Montana's expenditure per recipient is general higher than the national average. In other words, Montana serves fewer people but provides a richer benefit package than most states.

Over the years, Montana has made numerous efforts to improve services and control costs in the Medicaid program. These include:

a. The Home and Community Based Waiver in 1981;
b. The Passport To Health Program and restrictions on use of out-of-state hospitals in 1993;
c. The Lien and Estate Recovery Program in 1995;
d. The AFDC/HMO initiative in 1995;
e. Moving physician reimbursement to a Resource Based Relative Value System (RBRVS) in 1997; and

f. Mental Health Managed Care in 1997.

Each of these initiatives attempted to address a specific problem within the Medicaid program and generally targeted a single eligibility group, e.g., the elderly, developmentally disabled, children, or mentally ill. Each of the initiatives has had an impact. However, until now there has not been a comprehensive review and analysis of the total state Medicaid program. As currently structured, Montana's Medicaid program appears to be more a financing mechanism for individual programs and populations than a comprehensive health-care service delivery system with specific goals and objectives. At the same time, Medicaid has become an important source of outside revenue and a critical factor in the state's overall budgeting process. Decisions regarding the addition or deletion of health-care service are less a rational adjustment to an overall Medicaid system and philosophy than a reaction to budgetary constraints locked into existing statutes and regulations. In the absence of an overall plan, changes to the program appear increasingly arbitrary and difficult to defend.



The Redesign Process

As noted earlier, the Department initiated legislation during the 2003 legislative session to begin a comprehensive redesign of the public health programs administered by the Department. The resulting legislation, HJ 13, is presented in Appendix 1 (see page 79). From the beginning, the Department determined that unlike earlier efforts at cost containment that focused primarily on individual programs or specific populations, the current redesign effort would be comprehensive in nature and would include a review of all aspects of the Medicaid program, including eligibility issues, benefits and administration. Further, because the Medicaid program either directly or indirectly impacts the lives of literally hundreds of thousands of Montana citizens and involves huge sums of public funds, it was important that the redesign process include active participation by the public.

> *"We are determined that our redesign project will include the widest possible participation by the general public."*
>
> Gail Gray,
> Department Director

An initial step in the process was to identify a series of questions that articulated some of the core issues that would need to be addressed as part of any comprehensive redesign. This set of questions served to focus discussions among key administrative staff around the fundamental principles that would be incorporated in the subsequent development of specific recommendations. While many of the issues raised were primarily philosophical in nature and did not lend themselves to definitive answers, consideration of each of the issues as an integral part of the development of specific recommendations provided the basis for a consistent rationale across all of the recommendations included in the redesign of the program. Ultimately, no single value or principle determined a particular recommendation. Rather a balance among competing values needed to be achieved. For example, the value (and cost) of ensuring access to appropriate services must be balanced with the value (and cost) of adequate reimbursement for providers.

Core Issues Addressed

1. Underlying values of the program: Facilitating personal responsibility by recipients; maximizing recipient choice; insuring access to services; insuring quality of care; obtaining adequate reimbursement for providers; providing for public participation; protecting recipient rights; sharing risk among recipients and providers; insuring fiscal integrity.
2. Basic program philosophy: Is it better for a larger number of low-income people to have good – though not necessarily the most comprehensive – health coverage than for a small number of people to have the best possible coverage? Should selected optional services be restricted or eliminated to allow funding for expansion of eligibility for basic services? Where does the state's responsibility begin along the continuum of care relative to severity of illness? Should financial need take precedence over federally mandated eligibility categories such as family status?
3. Interface with health-care system: What role should other sectors of the health-care system play? What is an equitable balance between paying reasonable

reimbursement rates to providers and funding appropriate benefits? Is it possible to establish a system under which the private sector could assume some risk in exchange for profit? How much profit is legitimate (or politically tolerable)? What is the responsibility of the Medicaid program to the larger health-care system's problem of uncompensated care and the uninsured? Is it more important to use Montana providers than potentially more cost-effective out-of-state providers, specifically hospitals and mail-order pharmaceutical companies?

4. Role of Medicaid agency staff: If there is a significant change in the Medicaid program there will be a concomitant change in the role of Medicaid program staff. For example, if there is a strong push to place recipients in insurance programs, staff responsibilities will shift from fee-for-service billing to contract monitoring. What administrative adjustments will be necessary to implement a significant Medicaid change? Depending on the model adopted, it is likely that new expertise (insurance, risk adjustment, actuarial projections) will be required.
5. Individual responsibility: Can the recipients assume some of the risk in terms of their responsibility for timely and appropriate health care? What consequences can reasonably be imposed on recipients who do not assume their share of the risk? What incentives can be provided to recipients?
6. Incremental adjustment: Depending on the magnitude of change, what is the appropriate mechanism to implement the change? Should it be implemented incrementally? What component of the change should be initiated first? Should change be implemented statewide or by region? Is a pilot program justified? Is incrementally implementing a change in the program that may benefit or penalize certain recipients fair or legal? What period of time should be allowed? How does the legislative process fit into incremental implementation?
7. Finally, what is nice vs. what is practical.

Because Medicaid is administered by individual states, there is considerable variability among state Medicaid programs. Federal regulations govern the overall Medicaid program, but states are allowed some flexibility by requesting from the federal government a waiver of certain regulations. Using a number of different waiver programs, states have been able to test a variety of different approaches to meeting the health-care needs of their low-income populations. Obviously, some models have met with more success than others. No two states have exactly the same economic, social, and demographic characteristic, and consequently a national one-size-fits-all Medicaid system is not possible. However, the experience gained by other states with different models can be a very valuable resource in deciding what might work best for a state like Montana. Components of different state models were evaluated to determine if they could be modified and adopted as part of an overall Medicaid strategy for Montana. In addition to the services and eligibility design, important lessons can also be learned about the planning and implementation processes. Consequently, a review of other state initiatives was conducted. As a result of the review, some highly visible initiatives were rejected: Oregon's prioritization of services worked well when adequate funds were available but fell into disarray when the state began experiencing a severe budget crunch. Tennessee's wholesale move to managed care juxtaposed with Montana's own recent experience with mental health managed care did not seem politically possible. Other state initiatives were considered with modifications: Vermont's and

New York's waiver for seriously emotionally disturbed children, Utah's and Illinois' HIFA waivers to expand service to uninsured, and the efforts of several state to control escalating drug costs.

Public Health Care Advisory Council

Ultimately, decisions on recommended changes to the state's Medicaid program must remain within the Department, the Governor's Office, and the Legislature. Nonetheless, the Department was committed to making the Medicaid Redesign Project a public and transparent process. Therefore, it was crucial that a formal mechanism be established to solicit the broadest possible public input. In addition to the obvious advantages of gaining expertise, knowledge, and ideas from a wide spectrum of participants, there are two other important advantages to such an arrangement. First, so many different groups would be directly and indirectly impacted by significant changes to the Medicaid program that it was critical to develop as broad a base of support as possible for any potential changes. Second, trust and communication with the public, provider groups, advocacy groups, and recipients would be significantly enhanced through the effective use of known and respected representatives from each group.

For these reasons, Governor Martz appointed a 20-member Public Health Care Advisory Council (PHCAC). Representatives of a broad spectrum of individuals and groups that might be affected by changes to the Medicaid program were selected to assist the Department in developing recommendations for the Redesign Project. Appendix 2 (see page 82) presents the Governor's Executive Order creating the Council. Appendix 3 (see page 84) presents a full list of PHCAC members. A contract was also issued to the Montana Consensus Council to help facilitate deliberations of the PHCAC and its interactions with the Department. In addition, because the issues of Native American health care represent unique challenges in terms of culture and the intergovernmental relationships among the tribes, federal government and state government, Governor Martz requested that each tribal chair appoint a representative to serve on a separate subcommittee to evaluate and recommend changes to the Medicaid program as related to Medicaid services on the reservations and Native American health care in urban areas. Appendix 4 (see page 85) presents a full list of participants in the Native American subcommittee, which served a dual role of providing input back to the larger PHCAC and to the tribal chairs, who will meet with the Governor to discuss and resolve issues on a government-to-government basis.

It is critical that Native Americans, IHS, and tribal governments have appropriate representation in the Medicaid redesign process.

Rep. Jonathan Windy Boy, Advisory Council Member

From November 2003 through May 2004, the PHCAC held eight public meetings. During these meetings, the Council evaluated proposals presented by the Department, suggested additional areas of concern, and provided a tremendous amount of valuable feedback from the various perspectives represented. Over the course of the last four meetings, the PHCAC adopted a formal position on the specific recommendations put forward by the Department. The Council's recommendations and concerns are an integral and important part of the final recommendations contained in this report.

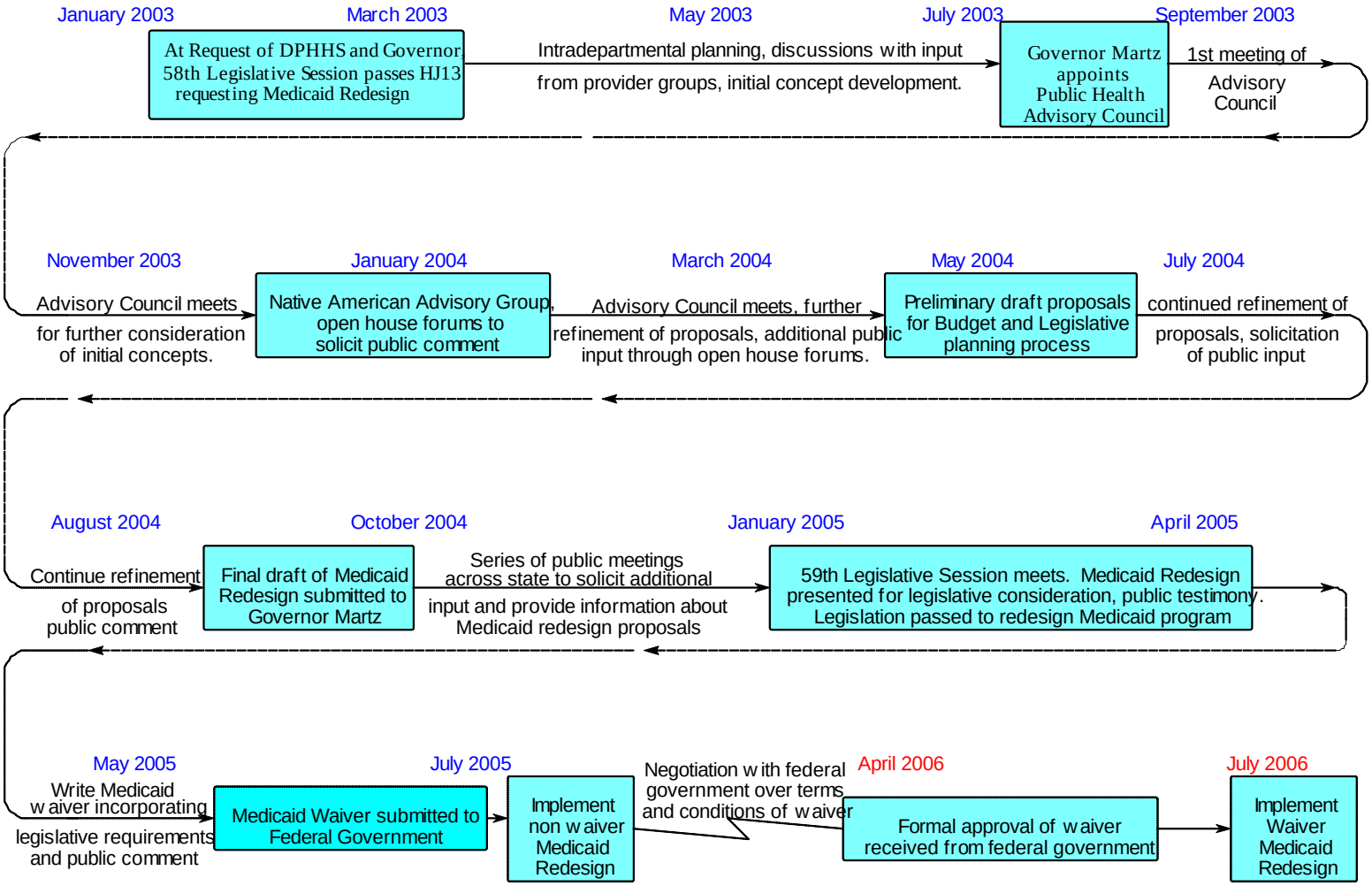
Finally, it is important to note that from its inception the entire Medicaid Redesign Project has been intended as a public process. Although this report represents the Department's formal recommendations, the ultimate decision on what direction Montana's Medicaid program takes in the future is a decision that rests with the Governor's Office, state's legislative representatives and, in those instances where federal waivers are required, the federal government. It is anticipated that as the recommendations are submitted to the 59th Legislature there will be ample additional opportunity for public discussion and debate around each of the recommendations contained in this report. Further, for those recommendations that include submission of federal waivers there will also be additional opportunities for public input and comment.

Timeline

Significant changes to a system as important and complex as Medicaid demand time. As noted earlier, the redesign process actually began during the 2003 legislative session with passage of HJ13. The Department immediately began an internal process of preliminary review of the program and determination of the overall framework for the redesign project. An advisory council was appointed to assist the Department in development of specific recommendations. Preliminary contacts were made with the state's federal partners at the Centers for Medicare and Medicaid Services (CMS). The formal recommendations will be submitted to the Legislature for consideration and action. Additional negotiations will be required with CMS to work through the technical details of federal waivers. Thus, at least for those major changes that will involve federal waivers, it is anticipated that final implementation of recommendations cannot occur prior to 2006 and possibly not until 2007. Figure 4 (see page 24) presents a graphic representation of the anticipated timeline for the overall Medicaid Redesign Project.

Figure 4

MEDICAID REDESIGN TIMELINES AND MAJOR MILESTONES



Note: The July 2006 implementation of the waiver may be overly optimistic. Federal approval of Medicaid waivers can take from 6 months to two years.

Part 2

Recommendations

The following sections of the report provide a more detailed analysis of each of the 18 recommendations made by the Public Health Care Advisory Council and the Native American Subcommittee. While an attempt has been made to provide sufficient information to allow the average reader to understand the general background and rationale behind each recommendation, the full details of the various proposals are beyond the scope of this report. Additionally, it should be noted that several of the recommendations, and in particular those involving a waiver of federal regulation, are in a preliminary stage. Until decisions are made by the Montana Legislature regarding certain aspects of the waiver application, such as the population(s) to be served, benefit package, and in some instances adjustments to appropriation, a complete and final analysis is not possible.

Figure 5 (see page 26) presents a summary of the recommendations, whether state legislative action is required, whether an appropriation adjustment is required, whether a federal waiver of Medicaid regulations is required, and the lead program assigned responsibility for implementation of the recommendation.

Figure 5
Summary of Medicaid Redesign Recommendations

Recommendation	Requires State Legislation	Requires Appropriation Adjustment	Requires Federal Waiver	Lead Division/Person
1. Fundamental Values, Principles, Goals	Potentially	No	No	Director's Office / Deputy Director
2. Incorporate Funding Principles	Potentially	No	No	Director's Office / Deputy Director
3. Management Principles and Data	Potentially	Yes (MMIS)	No	Director's Office / Deputy Director
4. Reimbursement Principles	Potentially	No	No	Director's Office / Deputy Director
5. Third-party Liability	No	No	No	QAD / Administrator
6. Eligibility Field Review	No	No	No	HCSD / Administrator
7. Community Health Center Project	No	No	No	CAHRD / Administrator
8. Strategic Plan for Adult Mental Health	Potentially	No	Potentially	AMDD / Administrator
9. Health Education Program	No	No	No	CAHRD / Administrator
10.Long-term Care Education	No	Yes	No	SLTCD / Administrator
11.Services for SED Children	Potentially	Yes	Yes	CAHRD / Administrator
12. HIFA Waiver	Yes	Yes	Yes	CAHRD / Administrator AMDD / Administrator

Figure 5 Continued
Summary of Medicaid Redesign Recommendations

Recommendation	Requires State Legislation	Requires Appropriation Adjustment	Requires Federal Waiver	Lead Division/Person
13. Pursue Changes in Medicaid Eligibility				
a. Extend Asset Transfer Look-back	Yes	No	Yes	HCSD / Administrator
b. Begin Penalty Period on Application Date	Potentially	No	Yes	HCSD / Administrator
c. Sanction Adult TANF Non-Compliance	Yes	No	No	HCSD / Administrator
d. Close Case After 10-day Notice	No	No	No	HCSD / Administrator
e. Long-term Care Insurance Partnership	No	No	Potentially	SLTCD / Administrator
f. Waiver of Deeming	Yes	No	Yes	DSD / Administrator
g. Delegate Eligibility Determination to Tribes	Yes	No	Yes	HCSD / Administrator
14. Seek Tribal Exemption	Potentially	Yes	Potentially	CAHRD / Administrator
15. Implement Pharmacy Cost Containment	Potentially	Potentially	Yes	CAHRD / Administrator
16. Family-planning Waiver	Potentially	Yes	Yes	CAHRD / Administrator
17. Transportation Brokerage	Potentially	Potentially	Potentially	DSD / Administrator

AMDD – Addictive and Mental Disorders Division
CAHRD – Children and Adult Health Resources Division
DSD – Disability Services Division
HCSD – Human and Community Services Division
SLTCD – Senior and Long Term Care Division

Part 2

Medicaid Values, Principles, and Goals

Background: Given the diversity of groups directly impacted by the Medicaid program—recipients, providers, legislators, bureaucracy, and taxpayers—there are inevitably conflicting goals and priorities among the various groups. The purpose of establishing a common set of fundamental values and guiding principles for the Medicaid program is to provide an agreed on balance among competing goals and a framework within which policymakers can make rational and predictable adjustments to the program. However, by their very nature, fundamental values do not lend themselves to precise definition. Rather, such values serve to focus the decision making process in a way that insures consideration of those issues and concepts deemed essential to the program. In the final analysis, achieving an appropriate balance among individual values is the difficult, imprecise but necessary process that provides the foundation for specific recommendations.

> *"A set of fundamental values must serve as the basis for all Medicaid policy decisions."*
>
> Sen. Bob Keenan, Advisory Council Member

Establishment of a set of common values and principles also provides the foundation for development of specific public policy goals with corresponding objective measures of accountability. The following five core values and associated principles reflect those qualities the Department believes are fundamental to administration of the state's Medicaid program.

Define Fundamental Values, Principles, and Goals

Value: *Access*

Principle: As part of an overall health-care system, Medicaid should insure access to a set of basic health-care benefits for those Montana citizens most in need and most vulnerable.

Policy Implications:

1. Determine the appropriate level of benefits necessary to meet the health-care needs of the different populations Medicaid serves: adults and children, the blind and disabled, and the elderly;
2. Given limited resources, establish the balance between providing minimally adequate coverage to more people or extensive health-care coverage to a smaller group;
3. Determine the appropriate level of allowable income and resources for Medicaid eligibility and insuring equity in access to services across all programs; and
4. Set adequate provider reimbursement levels to insure recipient access to services without jeopardizing benefits or eligibility.

Value: *Personal Responsibility*

Principle: Medicaid should facilitate responsibility among recipients for their own health-care decisions.

Policy Implications:

1. Incorporate a set of meaningful incentives and consequences into the Medicaid program to encourage appropriate recipient use of the program;
2. Provide some degree of choice for recipients with regard to provider networks, delivery systems, e.g. fee for service, private insurance, cash and counseling;
3. Establish eligibility criteria in a manner that reasonably insures that those who have the ability to contribute to their own health care expend their own resources prior to using publicly funded health-care programs; and
4. Allow for participation by family members and caregivers in development of treatment protocols.

Value: *Accountability*

Principle: The Medicaid system must be publicly accountable for quality of care and fiscal integrity.

Policy Implications:

1. Establish appropriate procedures and allocation of adequate resources to monitor quality of care;
2. Develop and maintain information systems that produce the necessary information and data to insure fiscal accountability; and
3. Establish processes and procedures to allow timely and appropriate adjustments to the program to meet unanticipated budgetary shortfalls;

Value: *Diversity*

Principle: The Medicaid program must be responsive to the needs of different cultures, the geographic availability of resources, and the severity of illnesses.

Policy Implications:

1. Develop programs that are sufficiently flexible to adapt to differences in availability of health-care resources in different regions of the state;
2. Within the overall framework of the Medicaid program, develop programs that address the unique needs of the state's Native American urban and reservation populations; and
3. Develop programs that equitably allocate resources across the diverse populations served by the Medicaid program, e.g. able-bodied adults and children; people with developmental, mental, or physical disabilities; and the elderly.

Value: *Public Participation*

Principle: Because Medicaid is a publicly funded program, significant decisions regarding changes to the program must incorporate opportunities for broad public input and must respect the opinions of all participants in the process.

Policy Implications:

1. Establish procedures to insure adequate public participation in significant policy decisions effecting the Medicaid program; and
2. Determine an appropriate level of resources necessary to insure public participation and public education regarding the Medicaid program.

The following table is an example of how fundamental values can be translated to specific policy goals with accompanying objective accountability measures.

Policy Goal # 1: Facilitate access to a set of basic health-care benefits for all Montana citizens with a priority for those most in need.	
Accountability Measures	1. Reduction in number of low-income uninsured.
	2. Reduction in number of Medicaid recipients refused services.
	3. Increase in number of providers participating in Medicaid program.
	4. Adequacy of Reimbursement rates across all providers.
Policy Goal # 2: Empower public-health-care users to take an active role in their individual health care.	
Accountability Measures	1. Increase in rate of participation in preventive health-care activities.
	2. Degree of choice available to recipients.
	3. Increase in collection rate of recipient cost sharing obligations.
	4. Reduced rate of fraudulent claims.
Policy Goal #3: Require accountability for quality of care and fiscal integrity.	
Accountability Measures	1. Effectiveness in insuring healthy outcomes.
	2. Degree to which available services correspond with medical necessity.
	3. Increased use of evidence-based practices
	4. Availability of timely and accurate program level fiscal status reports.
Policy Goal #4: Insure equity among various populations served by the program and be responsive to the needs of different cultures, geographic availability of resources and severity of illnesses.	
Accountability Measures	1. Degree to which Native American health-care needs are being met relative to overall population.
	2. Degree to which requirements for patient compliance correspond with the capability of the individual to comply.
	3. Balance of resource allocation according to need.
	4. Reduced barriers related to socio-economic status.
Policy Goal #5: Include opportunities for broad public input into decisions that significantly change program design or populations served.	
Accountability Measures	1. Availability of timely and accurate information distributed in a variety of formats.
	2. Open and inclusive processes; transparent public policy decisions.

Funding Priorities

Background: While the overall purpose of the Medicaid Redesign Project is the containment of expenditure growth to a level that is reasonable and sustainable into the future, the reality is that the Department must be prepared to deal with budgetary shortfalls. Simply stated, cost-cutting options essentially boil down to four alternatives: improve efficiency, pay less, cut services, or restrict eligibility.

Unfortunately, the inherent complexities of Medicaid make easy solutions impossible. Because Medicaid is a fungible system, cutting in one area can actually increase costs in other areas. For example, reducing provider rates can quickly result in restricted access to preventive care and subsequently increased costs for higher-end, long-term care; restrictions in eligibility often simply shift the costs to other public or private sectors of the health-care system with a corresponding loss of substantial federal funding. Thus, while it is easy enough to accurately calculate the savings realized from a specific dollar reduction in travel or the elimination of a specific capital expenditure, estimates of savings are far more slippery when adjustments are made to eligibility, implementing reductions or restrictions on various benefits or when changes are made in reimbursement levels.

> *"Future adjustments to Medicaid funding must follow a set of procedures equitably applied across all programs."*
>
> Rose Hughes, Advisory Council Member

With the above caveats in mind, it is imperative that the Department develops a broad strategy for addressing reductions to the Medicaid program that can be communicated to the general public, providers, recipients and the Legislature. However, each budget situation will present a unique set of challenges in terms of the actual dollar amount of reductions required and the current status of various aspects of the program such as existing reimbursement levels, service restriction, etc. Therefore, funding priorities or a cost-cutting strategy must be couched in general terms and serve primarily as a set of guidelines to be applied as circumstances warrant. Given the current status of information available, adjustments made to eligibility criteria are especially difficult to accurately project savings.

Incorporate Funding Priorities

The Department has adopted the following set of funding priorities. These priorities are predicated on the core values adopted by the Department of *access, accountability, personal responsibility, diversity*, and *public participation*. However, any decrease in funding will negatively impact some aspect of the Medicaid program. When considering future reductions, the Department's goal should be to attempt a balance of core values while insuring that services for those most in need and most vulnerable are protected.

In addition to the core values adopted by the Department, the Department has established a set of guiding principles to set priorities around the relative value of different aspects of the Medicaid

program that can be applied when budgetary constraints force decisions regarding reductions in Medicaid expenditures. These principles are as follows:

Client Need: From inception, the Medicaid program has been designed to serve as the final safety net for those individuals who through economic, social, or medical distress have no other recourse to essential medical care.

> ***Principle:*** When considering changes in policy or reduction in services, the Department and Legislature should first protect those most vulnerable and most in need as defined by the combination of the severity of their economic, social and medical circumstances.

Quality of Care: The Medicaid program must maintain acceptable standards of quality of care.

> ***Principle:*** When considering changes in policy or reduction in services, preference should be given to eliminating an entire program or service rather than sacrificing the quality of care for several programs or services through dilution of funding.

Quality of Life: The Medicaid program supports and funds the definition of *Health* as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Thus, Medicaid provides services beyond those necessary to protect life or prevent severe injury.

> ***Principle:*** When considering changes in policy or reduction in services, priority should be given to retaining those services that protect life, alleviate severe pain and prevent significant disability.

The funding strategy employed by the Department will incorporate the above principles in a double-tiered methodology. The first level represents the broad categories of administration, reimbursement, services, and eligibility, with a second subset of categories within each level. The second level categories are simply examples of general areas to be *considered* and do not necessarily correspond to a fixed menu of hierarchical choices. Any general cost reduction strategy must retain sufficient flexibility to adjust to the specific circumstances of a particular budget situation. Thus, the key word under the present strategy is "considered." The most likely scenario is that reductions will be made that may well include a combination of reductions in Level 1 and Level 2 categories from different areas.

Administration

Level A1: Non-essential administrative costs, e.g. travel, supplies, capital expenditures, equipment;
Level A2: Increased vacancy savings, hiring freeze;
Level A3: Elimination of systems enhancements/essential maintenance;
Level A4: Staff layoffs.

Reimbursement

Level R1: Freeze on selected appropriated inflation rate increases;
Level R2: Increased recipient cost sharing;
Level R3: Selective rate reductions;
Level R4: Across-the-board rate reductions.

Services
Level S1: Minor service restrictions for selected populations;
Level S2: Major service restrictions for optional populations;
Level S3: Elimination of selected optional services;
Level S4: Elimination of optional services.

Eligibility
Level E1: Reduced outreach efforts;
Level E2: Tighter asset criteria;
Level E3: Adjustments to income eligibility criteria;
Level E4: Elimination of selected optional eligibility categories.

Management Principles

Background: In 2003, Medicaid became the largest system of health-care services in the nation, serving more people and expending more public funds than Medicare. In Montana during fiscal year 2003, over 45 percent of childbirths were paid for through Medicaid and over 108,000 individuals were eligible for Medicaid benefits, including 65,000 children, 18,000 seriously disabled people, and 9,000 elderly people. State expenditures for Medicaid are expected to reach $650 million in fiscal year 2004 and to exceed $680 million by fiscal year 2005. Given the number and vulnerability of people who are dependent on Medicaid for their essential health-care needs and the very significant amount of public funding involved, it is essential that decisions regarding changes in benefits, eligibility, or allocation of resources are based on timely and accurate information.

Although fiscal accountability is an extremely important component of the overall management of the Medicaid program, of equal importance is a sound understanding of the characteristics of populations served, appropriateness of benefits provided, and the efficiency of service delivery systems. Too often decisions made strictly on the basis of financial considerations and anecdotal information result in significant unintended consequences that ultimately outweigh any fiscal savings. For example, a seemingly minor 2 percent across-the-board reduction in reimbursement rates may have relatively little impact on access to hospital-based services but a profound impact on access to personal care attendants and a devastating impact on the developmental disabilities service network.

Previously, the Department has not had the capacity or inclination to adequately evaluate the crucial role eligibility determination plays as a primary gatekeeper for Medicaid services. Historically, the eligibility process has been more closely aligned with the general welfare functions of the Department (e.g. TANF, food stamps, etc.) than coordinated with policies directly effecting Medicaid. An important part of the redesign process has been a thorough examination of all the various ways individuals become eligible for Medicaid services (there are currently over 30 different paths to Medicaid eligibility) and establishment of procedures that insure consideration of eligibility as a key component during any future considerations of changes to the program.

"States must shift to more integrated enterprise-wide eligibility determination systems."

CMS,
Data Systems
Publication

A particular area of concern for the Department is the adequacy and accuracy of data and management issues related to Medicaid services provided to Native Americans. Each federally recognized tribe has a somewhat different governing structure and process for providing Medicaid services. Some rely exclusively on IHS, some are covered under Public Law 93-638 and provide part of the health-care services directly with other services provided by IHS, and some tribes have a compact with the federal government and receive a direct appropriation from Congress.

There are a number of advantages to the current administrative structure of Montana's Medicaid program. The fact that the four administrative divisions focus on selected populations within the Medicaid program (such as children, pregnant women, the mentally ill, the elderly, or the developmentally disabled), rather than including all populations under a single administrative unit, makes it possible to more clearly target resources and services to meet the special needs of the different populations. At the same time, there are legitimate differences in priorities that can create confusion and frustration among both recipients and providers if the Department does not have a common set of management principles and policies that, when applied, result in uniform and predictable interactions.

Implement Management Principles and Data Analysis

To meet the challenges associated with timely management of a program as complex and important as Medicaid, the Department has established the following set of explicit principles and expectations for each division responsible for Medicaid services and those staff charged with administering the Medicaid program. The Director of the Department will periodically review the overall status of the Medicaid program and compliance with established principles and procedures. The management principles include the following components:

a. Overall supervision, coordination and accountability for all aspects of the Medicaid program are vested in a single individual, the state's Medicaid director;
b. To assist the Medicaid director and division staffs, a special unit called the Office of Planning, Coordination, and Analysis has been established to coordinate, establish common formats, collect and analyze Medicaid data. This unit will also have sufficient resources to provide technical assistance to staff at the program level regarding use of data and common budgeting format;
c. The Department's exiting major computer systems for tracking eligibility and service utilization (TEAMS and MMIS) will be revised to coordinate information databases to allow tracking service utilization information by population groups, enhance eligibility determination including demographic and resource information, and an improved Decision Support System that will allow program managers easy and timely access to expenditure data;
d. Each program manager will be directly involved in the initial development of his/her program's budget and will be provided a clear understanding of the assumptions and process used to derive the Department's final annual budget for the entire Medicaid program;
e. After legislative approval of the Department's annual Medicaid appropriation, each program manager will be provided a detailed copy of the appropriations supporting the program he/she is responsible for managing;
f. Throughout the fiscal year, program managers will provide periodic budget status reports of expenditures and utilization trends within their programs. On a timely basis, these budget status reports will be compiled and reviewed by the Medicaid director in collaboration with other information and analysis conducted by the Division of Operations and Technology and budget staff assigned to the Director's Office. This information is shared with the Governor's Budget Office on a routine basis;

g. With appropriate input from program managers, division administrators will be responsible for early identification of potential fiscal pitfalls and the policy adjustments that might be necessary to contain expenditures within authorized appropriations;
h. Because changes to services, eligibility, or reimbursement levels within one aspect of the Medicaid program can have serious ramifications for other aspects of the program, prior to implementation of any significant adjustments within a single program, information will be shared across all programs to avoid unintended conflicts;
i. Every proposed change in the Medicaid policy will include an assessment of the potential human and fiscal impact of the change as well as a method of evaluating the actual impact of the change if implemented;
j. The Department will develop a 10-year historical record of Medicaid program expenditures and utilization data by services including a description of program/policy changes, when they were implemented, the reason why they were implemented and an assessment of their impact; and
k. The Medicaid director will insure that division administrators and program managers have access to the resources necessary to effectively manage their programs: specifically, training and user friendly access to appropriate data systems. Given adequate resources, division administrators and program managers will be individually accountable for the quality and fiscal integrity of their respective programs.

In order to deal specifically with data and management issues effecting the tribes and IHS, the Department will work with tribes to foster a spirit of cooperation and identify current institutional barriers limiting the participation of tribal members in the Medicaid program and develop strategies, including education, to improve the mechanics of providing Medicaid services to Native Americans by:

a. Insuring that tribes have an adequate opportunity to review and verify data used to monitor Medicaid services and eligibility status, as well as data used to modify or promote changes in Medicaid policy;
b. Consulting with tribal representatives on the effective use and appropriate sources of information on Native American health-care needs; and
c. Conducting technical assistance workshops, at the request of tribal representatives, to address issues specific to tribal needs regarding such matters as centralized billing procedures, sound health-care business practices, and development of needed health-care infrastructure.

In addition, the Department will insure compliance with requirements of HB 608 by consulting directly with the tribes on any policy changes that may impact services or programs operated by the tribes.

Reimbursement Principles

Background: Establishing appropriate levels of Medicaid reimbursement or provider rate increases is not a simple matter. Montana's Medicaid program includes over 12,000 service providers operating under a variety of different reimbursement mechanisms. For a number of reasons, Montana's Medicaid program does not have a rational system for adjusting provider reimbursement rates that can be equitably applied across all the various provider groups. As a consequence, provider rate increases have historically been implemented primarily on an individual program basis in response to specific crises or political pressure. Given the status of Montana's economy into the foreseeable future, it is critically important that the state develop the data and processes necessary for policymakers to make informed decisions regarding adjustments to reimbursement levels in a manner that is objective, publicly verifiable, and equitable to all provider groups.

"It doesn't matter what benefits you offer, if reimbursement is so low that providers won't participate, you have NO access."

R.D. Marks, Advisory Council

The amount and manner of reimbursement Medicaid pays providers for the services they deliver has a significant impact on a number of important aspects of Montana's health-care system. Inadequate reimbursement levels can impact the overall quality of care delivered, the degree to which Medicaid recipients have access to health-care providers and services, the number and type of services provided, the ability of service providers to attract and retain qualified staff, the amount paid for services by other purchasers of health care, and the overall financial stability of the state's health-care system. On the other hand, if Medicaid pays too much for selected services, inappropriate changes in service utilization patterns may occur in order to maximize provider revenue, issues of equity and fairness between providers of different types of services are exacerbated, and scarce resources become unavailable for other services and programs.

As noted, Medicaid does not operate under a single reimbursement system. Over the years, an extremely complex series of different reimbursement systems have evolved in an effort to meet the needs of various provider groups. For example, Medicaid reimburses for physician and professional services using a modification of the federal Medicare payment system (RBRVS) based on the relative value of the service provided. Inpatient hospital charges are based on another federal payment system (DRGs) that sets a flat payment according to specific diagnosis and average length of hospital stay, regardless of the actual hospital cost. Nursing homes are reimbursed according to a complex formula that sets an overall average rate per day adjusted for acuity level of residents and a lump sum payment of Inter Governmental Transfer (IGT) funds depending on whether the facility is privately operated or county owned.

Other entirely different systems are used for calculating reimbursement for out-of-state hospitals, Community Mental Health Centers, Federally Qualified Health Centers, state-administered institutional care, Durable Medical Equipment, and the level of reimbursement (premium) paid for the Children's Health Insurance Plan (CHIP) or any future insurance premium assistance program the Department might propose.

Another important factor that must be taken into consideration is the relative importance of Medicaid reimbursement against the total revenue received by a given provider. If providers are dependent upon Medicaid as their primary source of revenue, then even minor adjustments to the reimbursement level will have a significant impact on their ability and willingness to provide services. For those providers for whom Medicaid accounts for a lesser portion of their overall revenue, other strategies, e.g. less administrative overhead, might prove to be a more effective incentive for increasing access. For illustrative purposes, Figure 6 presents a comparison of selected Medicaid providers and the percentage of their overall revenue that Medicaid reimbursement accounts for.

Figure 6
Medicaid as a Percentage of Total Revenue

Provider	% Total Revenue
Other Professionals[a]	4%
Dental[a]	5%
Physician & Clinical[a]	7%
Hospital Services[a]	17%
Nursing Home[b]	60%
Community Mental Health Centers[b]	67%
Personal Assistance Services[b]	87%
Developmental Disabilities Services[b]	99%

[a]National data from *Health Affairs*, January 2003
[b]Estimated Montana data.

As Figure 6 indicates, even minor adjustments to developmental disability, personal assistance, or nursing home provider rates can have a far more profound impact on access to services than comparable adjustments to rates paid to other professionals or even hospitals.

A prerequisite to establishing a fair and objective reimbursement system is a common base of objective data for each of the various reimbursement mechanisms. Once the data are acquired, procedures need be established to insure any policy decisions regarding adjustments to reimbursement rates are based on objective criteria and equitably applied to all providers.

Implement Common Set of Reimbursement Principles for All Medicaid Providers

The Department should develop the data and process necessary for policymakers to make informed decisions regarding adjustments to reimbursement levels in a manner that is objective, publicly verifiable, and equitable to all provider groups. Such data systems and process would include the following:

1. In order to establish a common database of information for all Medicaid service providers and populations served by the Medicaid program, and to provide accurate, consistent and timely budget information, each Medicaid program should conduct the following activities:
    a. Gather, analyze and compare all data currently available regarding the actual and reasonable cost of providing Medicaid services;
    b. Require providers of any service category or type for which Medicaid is the primary payer to submit audited data on the actual cost of providing that service;
    c. Conduct a cost-of-care analysis, including children's mental health services and other services highly dependent on Medicaid reimbursement;
    d. Gather, analyze and compare the rates paid by other purchasers of the same or similar services to those paid by Medicaid;
    e. Establish an objective definition of reasonable access to care;
    f. Gather and analyze data and information related to the access to care such as the number of Medicaid providers of the services, trends in utilization of the services and any other pertinent information available to the Department;
    g. Where possible, assess the impact of changes in reimbursement on the utilization of services and quality of care; and
    h. Gather and analyze data on the percentage of total service provider revenue that is derived from Medicaid for each Medicaid service.

2. In addition and where applicable, the Department should conduct an analysis of the following options as alternatives to specific dollar increases in reimbursement rates.
    a. Providing tax incentives for providers who deliver services to Medicaid recipients;
    b. Paying a higher reimbursement rate to providers who serve a high number of Medicaid recipients;
    c. Making pretax payments into the deferred compensation accounts of individual providers;
    d. Simplifying and expediting the Medicaid billing and payment systems and requirements; and
    e. Streamlining and simplifying administrative requirements and regulations where possible while continuing to protect the health, safety and welfare of Medicaid recipients.

3. When adjusting Medicaid reimbursement rates, the Department should evaluate all requests against a common set of criteria to insure a rational and objective process is used that is

equitably applied to all provider groups. The relative status of each provider group should be measured against the following set of criteria:

a. The actual, reasonable costs of providing each service at the level of quality required by law and/or regulation;
b. The reimbursement rates paid by other public and private purchasers of the same services;
c. The impact of the reimbursement rates on Medicaid recipients' access to medically necessary care;
d. The degree to which the reimbursement rates encourage the use of the most appropriate medically necessary services;
e. The impact of the reimbursement rates on the quality of care delivered to recipients;
f. The degree to which the providers of care are dependant on Medicaid revenue for this service; and
g. The level of funding, and any specific directions, provided by the Legislature.

The Department should also work with tribes and the IHS to engage CMS and Congress to support efforts to have all services for Medicaid-eligible Native Americans included in the State Medicaid Plan be eligible for 100 percent FMAP regardless of the location where services are provided.

Third-party Reimbursement

Background: According to federal law, the Medicaid program is intended to be the payer of last resort; that is, all other liable third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. The Social Security Act that authorizes Medicaid includes a requirement that each state must take all reasonable measures to enforce the payer-of-last-resort provisions by identifying legally responsible third parties and pursuing payment of their legal obligations. To comply with these federal requirements, the Department operates two closely related functions: Third-party Liability (TPL) and the Lien and Estate Recovery.

Third-party Liability (TPL) includes cost avoidance and recovery resulting from the identification and verification of other insurance. "Other insurance" falls under several categories, such as:

a. Regular health insurance coverage for Medicaid recipients, including coverage provided through employment;
b. Health insurance coverage provided for children by an absent parent;
c. Workers' compensation coverage for health-care costs associated with a job-related injury; and
d. Casualty insurance coverage for health-care costs resulting from some sort of trauma/injury, such as an automobile accident.

Fortunately, the federal government affords states the flexibility to determine which TPL efforts are cost-effective. For instance, states have the ability to "purchase" health insurance coverage for Medicaid clients when it is deemed cost-effective to do so. Montana engages in the payment of Medicare and other insurance premiums for some eligible recipients when the cost of the premium is less expensive than the cost to Medicaid for health-care-related services.

Lien and Estate Recovery primarily consists of the recovery of funds from the estates and property of deceased Medicaid nursing home clients. Medicaid beneficiaries are notified of the Medicaid estate recovery program during their initial application for eligibility and again during the redetermination process. If the Medicaid recipient owns property, the state places a lien on the property when he or she enters the nursing home. Certain exemptions apply if someone else (spouse, child under the age of 21, etc.) is still residing in the home. In addition, as Montana's aging population increases, it is essential that the Department not only maximize efforts for lien and estate recovery, but coordinate efforts between the Lien and Estate Recovery Unit and activities pursued by the Senior and Long Term Care Division to promote long-term care insurance and the Long-Term Care Insurance Partnership initiative.

The TPL and Lien and Estate Recovery functions are particularly critical because they are an integral part of the revenue side of the Medicaid budget. Having a strong and productive TPL and estate recovery programs can increase state revenues and help reduce the need for painful reductions to the Medicaid program. Additionally, federal statute and taxpayers alike expect

Medicaid recipients to exercise personal responsibility by assisting with their health-care costs whenever possible.

Maximize Third-party Liability and Lien and Estate Recovery

As a condition of participation in Medicaid, each state is required to have a "TPL Action Plan" as a separate component of the overall State Medicaid Plan. The Department is currently reviewing and updating Montana's TPL Action Plan, as well as the internal TPL Procedures Manual. As part of the review and revisions to the Action Plan and Procedures Manual, the Department should incorporate specific procedures and process to enhance opportunities for maximization of Third-party Liability (TPL) recoveries for Medicaid through:

a. Lien and Estate Recovery;
b. Third-party Insurance;
c. Trauma-related Insurance and Settlement (i.e., car accidents, etc.);
d. Workers' Compensation;
e. Health Insurance Premium Payments (HIPPS) when cost-effective;
f. Buy-in of Medicare Coverage for those eligible;
g. Recoupment of Medicaid costs through third-party assets when possible; and
h. Maximization of TPL capabilities during development of the new Health Care Eligibility System (HCES).

Medicaid Eligibility Field Review

Background: As the Montana Medicaid program evolves into a more complex, widely used health-care system, considerable dollars are at stake should errors be made in the process of determining eligibility for the program. Currently, over 270 employees of the Human and Community Services Division (HCSD), located in offices across the state, make over 20,000 Medicaid eligibility determinations every year. The criteria for eligibility are extremely complex and are constantly changing. The federal government routinely increases the program's complexity by adding new eligibility options and programs and an expanded role for eligibility staff with few new resources. A recent example of enhanced eligibility responsibilities is the national movement toward identifying dually eligible Medicaid and Medicare recipients, and partnering with the federal agency in the area of prescription drug coverage for seniors. All of this makes it even more important that each staff person in the process be as accurate as possible when determining eligibility for these very expensive services.

Implementing a rigorous internal field review of the eligibility determination process, from the initial application through issuance of the Medicaid card, has the potential to improve the accuracy of the Medicaid eligibility determination process and the potential for saving significant amounts of money. Previous experience indicates that positive results in decreasing errors and potential errors can be realized by conducting on-site, thorough reviews of large numbers of cases, and by increasing the expertise of staff that are involved in the process.

Currently, the Department operates a federally mandated food stamp evaluation process. It is an internal process within the Public Assistance Bureau designed to identify and correct any errors made in food stamp eligibility determinations, and to assure that the overall application and authorization process is completed within the allowable time frames. Rigorous and consistent internal review assures very accurate eligibility determinations and provides immediate opportunity to train staff in areas where errors are made or policy is being misapplied. On-site reviews in county Offices of Public Assistance enhance communication and are an effective use of the bureau's expert resources as they provide more ability to respond to technical and complex questions about food stamp eligibility decisions.

Implement Medicaid Field Review Process

A Medicaid eligibility field review process should be established using a model similar to the current food stamp eligibility review process. Prior to an actual on-site review, several hundred cases should be reviewed "on-line" to identify any outstanding issues, miscoding, questionable elements of the process, and patterns of problems that need to be addressed once the on-site review begins. Any identified weaknesses should be addressed immediately through targeted training and policy clarification. While the review team is on-site, they should also interview local providers including hospitals, nursing homes, and physicians to determine the quality of services. Also, in those areas with a significant Native American population, the review team

should take particular care to insure appropriate representation of Native American recipients and providers in the review process. Clients should be interviewed for the same purpose and to ask for any suggestions for improvements in the eligibility process. Staff should be interviewed individually to determine if they are comfortable with and knowledgeable about policy, whether they follow the federally mandated time frames for processing, how they assure that confidentiality of client information is maintained and civil rights are protected, and other questions relevant to their expertise in the positions they hold. County Offices of Public Assistance log all complaints, and the reviewers should evaluate the complaint log to determine if there are any patterns of concerns that need to be addressed with management and staff. Access to the program, worker availability, hours of operation, and general management practices should also be assessed.

Because there are some unique issues around Native American eligibility, the Department should also develop a policy and process to periodically review Native American eligibility issues as they relate to Medicaid and to include tribal government and IHS representation in the development of such policy and processes. Field reviews conducted by the Department on or near reservations or urban areas with significant Native American populations should involve representatives of tribal governments and urban Native American programs.

The Department estimates that a field review process for Medicaid eligibility would require two grade 15 FTE. Additionally, the two FTE would serve as a resource and a "second pair of eyes" for the most difficult cases involving multiple resources, trusts, and the less common assets that must be evaluated in a resource assessment, thus assuring that cases are determined correctly initially, preventing overpayments by Medicaid in the future.

Community Health Center Demonstration Project

Background: The current fee-for-service system of providing health-care services to Medicaid recipients presents a series of challenges to recipients, providers, and to the Department. Two major concerns are recipient access to health-care services and the Department's inability to control or accurately predict future costs. For a variety of reasons, many physicians do not accept Medicaid clients or restrict the number of clients they will see in their practice. In addition to insuring that a provider is willing and available to accept the Medicaid recipient, *appropriate access* also includes such issues as continuity of care, quality of care, reduction in the inappropriate use of the emergency room, and coordination of health-care services.

To address some of the above issues of recipient access, the Department has explored the option of contracting with one or more federally funded Community Health Centers (CHCs). Originally know as neighborhood health centers in the mid-1960s, CHCs provide comprehensive primary medical care to medically underserved areas or medically underserved and vulnerable populations. CHCs are a type of Federally Qualified Health Center designated to receive federal funding under Section 330e of the Health Centers Consolidation Act of 1996. Centers must either provide or arrange for a full spectrum of primary and preventive health-care services, including routine physician services, diagnostic laboratory and x-ray, preventive health services including prenatal and perinatal care; disease screening; well-child services; immunizations; family-planning services; pharmacy services; case management; transportation; and health education services. Additionally, centers may offer dental, substance abuse, and mental health services.

Using an 1115 Waiver, the Department could contract with a CHC to become the primary or exclusive provider of primary and preventive health care to the adult and child segment of the Medicaid population in the CHC's catchment area. Because the CHC would be designated as the sole provider of care, eligible recipients would also benefit from access to a single, stable medical environment with the capacity to provide dental, pharmaceutical, laboratory and x-ray, and transportation services in addition to routine physician services. Such a contract could also provide for 24-hour coverage, case management and referral services including prior authorization of any emergency room use, specialty care, or inpatient or outpatient hospitalization.

Dealing with a single provider in a health-care catchment area would offer several important administrative advantages. One contractual option would be to negotiate a capitated rate per Medicaid recipient, which would provide the Department with a more stable and predictable budgeting process. Alternatively, given the large increase in revenue through a guaranteed Medicaid population, the CHC could negotiate a more favorable reimbursement rate than is possible with the limited number of Medicaid clients they currently serve. Although subject to many of the same inflationary pressures inherent in the general health system, the not-for-profit public structure and mission of the CHCs tend to mitigate some of the more significant

administrative costs. For example, because CHCs are protected under the Federal Tort Claims Act they are not subject to substantial and ever-increasing malpractice insurance costs.

With a stable and predictable source of revenue generated from the Medicaid population, it should also be possible for the CHCs to support additional health-care services for other non-Medicaid, low-income populations thus reducing the impact of uncompensated care on other health-care providers in the community.

Coordinate with Community Health Center Programs

At this time, it does not appear feasible to develop a comprehensive contract with one or more CHCs to become the principle or exclusive provider of Medicaid primary health care for a designated catchment area. A number of issues still need to be resolved regarding the ongoing relationships with other medical providers in the community, the degree to which there is in fact a significant access issue for Medicaid recipients, the consequences of restricting all Medicaid recipients to a single provider of primary health care, and the fact that many of the CHCs in Montana are relatively new and not firmly established in their communities. For these reasons, the Department is not currently pursuing such a contract. However, the Department does view the CHC network as a valuable resources and will continue to work with the CHCs to define a more active role for the CHCs within the overall Medicaid service delivery system.

The Department will also explore the potential for additional Critical Access Hospitals participating in the federally funded Community Health Center program as a mechanism for expanding health services in rural areas.

Strategic Plan for Adult Mental Health Services

Background: Montana's mental health service delivery system has undergone a series of tumultuous changes over the past decade. For many years, the system operated on a standard fee-for-service basis with the vast majority of services provided through a network of five regional community mental health centers. When costs for mental health services began to escalate in the mid-1990s, the state began looking for mechanisms to control them. In 1997, Montana entered into a single, statewide contract for mental health managed care services. For a variety of reasons, the attempt to implement a statewide mental health managed care system failed, and in 1999 the state chose to revert to the standard fee-for-services model. Although the brief experience with managed care led to the creation of some valuable new services, such as the Mental Health Services Plan (which provides services to qualified individuals with severe disabling mental illness), it unfortunately left the state with some significant gaps in services as well. The demand for services again escalated and expenditures quickly exceeded the legislative appropriation. In 1999, the Legislature formed the Mental Health Oversight Advisory Committee to provide advice, oversight, and a consistent vision for short and long-term strategic planning to the Addictive and Mental Disorders Division. In 2003, the Department created separate administrative divisions for children's and adult mental health to better focus resources on the different needs of the seriously emotionally disturbed child and adults with serious mental illness.

Through all these changes, Department staff have struggled to maintain services with a primary goal of serving people with severe disabling mental illnesses in the least restrictive environments and efficiently transitioning people from higher levels of care back into community-based services.

Still, there are continuing and new issues that need to be addressed.

During the 58th Legislature, legislation was passed creating at least three Service Area Authorities (SAAs). The SAAs are intended to bring all mental health system stakeholders (consumers, providers, families, advocates, local government officials, interested citizens) together to share authority and responsibility for determining service needs and using resources in the most efficient and effective way possible. In many respects, they may be classified as non-provider, quasi-governmental entities. Over a four-year period, the Department will be responsible for assisting in the development of the SAAs, helping to define the range and scope of their participation in the state's mental health system, and delegating to them certain administrative and management functions as they become able to assume those duties. This is an ongoing evolutionary process that will take time but one that the Department strongly supports.

The Montana Mental Health Nursing Care Center in Lewistown is currently operating at 42 percent of its licensed occupancy. Hard decisions need to be made about the best and most appropriate use of this facility for the future.

The Montana State Hospital, licensed for a total of 189 beds (funded at an expected 175-bed occupancy level), is operating at full capacity and periodically exceeds the intended occupancy level. The forensic population (people sent to the hospital pursuant to criminal proceedings) comprises a third of the patient population, and this population is expected to continue to increase in the near future. Many of the hospital's admissions are patients who appear to have a primary substance abuse problem rather than a primary mental health disorder. In fact, about 60 percent of all individuals served at the hospital who are mentally ill also are chemically dependent. Additionally, far too many admissions are for people who cannot access more appropriate alternative services in their local communities. Hospital stays are frequently extended due to the difficulty in accessing more appropriate lower-end, community-based services after discharge.

The Montana Chemical Dependency Center (MCDC) is licensed for 76 beds but is unable to accept that many people because it cannot recruit sufficient staff. Consequently, there is a continuing waiting list of individuals seeking and needing admission. There are currently not enough community services to either keep people out of MCDC or for them to successfully re-enter the community with the necessary support services.

Finally, Montana's mental health service system continues to operate on a medical treatment model rather than a recovery model. While some strides have been made, much is left to do.

Develop Strategic Plan for Adult Mental Health Services

It is essential that adequate time, resources, and public input be devoted to a thoughtful review of how the state wants its mental health system to evolve over the next five to ten years. To achieve this goal, the Department believes it is important to aggressively pursue development of a comprehensive strategic plan. This plan would describe an enhanced service delivery system for the adults with mental illness that reflects the following components:

a. Develop at least three Service Area Authorities to work in partnership with the Department in the planning and delivery of mental health and chemical dependency services;
b. Review the mission, utilization and admission practices of state operated facility-based services provided by Montana State Hospital, Montana Chemical Dependency Center, and Montana Mental Health Nursing Care Center;
c. Develop a written strategic plan to implement a system of facility-based care that is appropriate to need, focuses on rehabilitation and treatment, and provides a clear definition of the role and complementary purpose of each facility in the context of the larger community-based system of care;
d. Develop a system of community services that addresses both crisis stabilization and a full range of recovery-based services;
e. Develop procedures that emphasize and adequately reimburse those providers that deliver demonstrated evidence-based services;

f. Encourage culturally sensitive and appropriately trained mental health providers to provide services to Native Americans living on reservations or in urban areas with significant numbers of Native American peoples; and
g. Develop a service delivery system that is capable of meeting the needs of adults with severe and disabling mental illness while containing costs within the levels appropriated by the Legislature.

Long-term Care Education Campaign

Background: "Long-term care" is a generic term that generally refers to the medical, social, and other services designed to meet the ongoing need for support and assistance that people often experience as a result of the aging process, a severe disability, or an injury. Such services can be provided in a variety of settings including an individual's own home, assisted living facilities, or nursing homes. Depending on what is included in the definition, long-term care accounts for well over 25 percent of total Medicaid expenditures. The federal Department of Health and Human Services estimates that 60 percent of the people reaching age 65 will require some long-term care during their lifetime. As Montana's population continues to age, this demand for long-term care services will inevitably increase.

The cost of long-term care can be very high. Nursing home care is expensive: today, the national average cost of a semi-private room in a nursing home is $52,000 annually. Depending upon location and the type of facility that is preferred, costs can be significantly higher. Home health care is also expensive. In the case of some individuals it can exceed the cost of care in a nursing home. The national average annual cost of home health care is well over $20,000 (that's $18/hour, five hours per day, five days a week for a home health aide). Without adequate planning and preparation, any extended use of long-term care services can quickly drain all of an average family's resources.

Unfortunately, very few people understand the importance of planning for their own long-term care needs. Far too many simply assume they will never need such care or that if they do the government, through Medicare or Medicaid, will automatically pay for the cost of care. In an era of increasing demand and ever-scarcer resources, it is critical that people understand long-term care issues and the various options available to them. To the extent they are able, people must assume responsibility for their own long-term care and avoid inappropriate reliance on publicly funded programs such as Medicaid.

Medicaid can and should have a major role in promoting such individual responsibility by providing information, education and assistance around long-term care issues.

Implement Long-term Care Education Campaign

The Department, in collaboration with other agencies involved with long-term care issues, should develop and implement a continuing public education campaign to inform Montanans about long-term care issues and options. The program should include the following components:

a. The Senior and Long Term Care Division should assume the lead role in the development of the program and coordination with other appropriate agencies;
b. Information should be provided that emphasizes the need for individual long-term care planning and assumption of personal responsibility for individual health-care needs;

c. A description of the options available for long-term care insurance should be provided as well as information on changes in the Medicaid program such as the Long Term Care Insurance Partnership Program; and
d. Information should be provided about current Medicaid regulations regarding transfer of assets and the consequences of inappropriate transfer in anticipation of receiving Medicaid benefits.

Public Health Education Program

Background: To the extent that individuals are adequately informed and take personal responsibility for their own health care, there is the potential for significant improvement in the general health status and reductions in the overall costs of both publicly and privately funded health care. It is a well-researched and documented fact that prevention and health education can significantly reduce health-care costs and improve quality of life. In fact, the 30-year or more increase in life expectancy that has occurred over the past century has been due primarily to improvements in public health, sanitation and changes in personal lifestyle rather than the more publicized technical advances in medical care and treatment. In large part, these advances are closely related to an increased understanding and application by the general public of the principles underlying healthy lifestyles and appropriate use of the existing health-care system.

While significant advances have been made, it is also true that as the system changes and alternative choices become available there is a continued need for appropriate and timely education. Because Medicaid has such a major role in public health-care funding, it is important that the Medicaid program actively participate in a variety of health education programs that target those populations that currently use Medicaid services or potentially could become Medicaid recipients. Adequate and timely information are powerful tools that individuals can use to take responsibility for their own health care and long-term health-care future. The Medicaid program has a responsibility to assist in developing and disseminating those tools. However, such a broad public education program is not the sole responsibility of Medicaid but must be a collaborative effort among the larger group of health-care participants including health-care providers, insurance companies, advocates, and the public education system.

Additionally, as the Medicaid program makes policy adjustments to the program, it is essential that the Department invest in outreach to inform recipients and potential recipients of forthcoming changes.

Participate in Health Education Program

In collaboration with other health-care agencies, the public school system, and various low-income and advocacy groups, the Department should work to develop an appropriate health education program that includes the following characteristics:

a. General education for grades K-12, emphasizing health and nutrition, life skills including appropriate access of the health-care system, health-care finances, nutrition and the consequences of lifestyle choices, and physical education for all ages;
b. Education for specific disease management programs that targets individuals diagnosed or at high risk.
c. Development and dissemination of information that measures the effects of implemented disease management programs;

d. Availability of education programs at multiple access points including middle school and high school, eligibility offices for new Medicaid recipients, hospital emergency rooms, follow-up care situations, and doctor's offices;
e. Information widely dispersed and easily accessible using a variety of public and private media; and
f. Education programs that are age, culturally, and access-point appropriate.

The public health education program should be developed in conjunction with Recommendation #9, Development of a Long-term Care Education Campaign.

Services for Seriously Emotionally Disturbed Children

Background: As noted earlier, Montana's mental health service delivery system has undergone a series of tumultuous changes over the past decade. For many years, the system operated on a standard fee-for-service basis with the vast majority of services provided through a network of five regional community mental health centers. When costs for mental health services began to escalate in the mid-1990s, the state began looking for mechanisms to control the rising costs. In 1997, Montana entered into a single, statewide contract for mental health managed care services. For a variety of reasons, the attempt to implement a statewide mental health managed care system failed, and in 1999 the state chose to revert to the standard fee-for-services model. Although the brief experience with managed care led to the creation of some valuable new services, such as the Mental Health Services Plan (which provides services to qualified individuals with severe disabling mental illness), it unfortunately left the state with some significant gaps in services as well. The demand for services again escalated, and expenditures quickly exceeded the legislative appropriation. In 1999, the Legislature formed the Mental Health Oversight Advisory Committee to provide advice, oversight, and a consistent vision for short and long-term strategic planning to the Addictive and Mental Disorders Division. In 2003, the Department created separate administrative divisions for children's and adult mental health to better focus resources on the different needs of the seriously emotionally disturbed child and adults with serious mental illness.

The creation of a new administrative division that includes a bureau dedicated exclusively to issues relating to mental health services for youth under the age of 18, provides the Department an opportunity to refocus efforts and planning around a new service system that can be more effective and uniquely tailored to meet the specific needs of the children and families of the state's Seriously Emotionally Disturbed (SED) children.

> *"Our goal is to develop an integrated, family-based system of services."*
>
> Chuck Hunter, Administrator CAHRD

While services and costs associated with SED children have grown at a rate that significantly exceeds the rate of growth in other sectors of the Medicaid program, there has been considerable dissatisfaction among consumers, providers, and state managers around the cost effectiveness of the existing service system and the appropriateness of the underlying philosophy driving the current clinical model.

One approach to dealing with the issues of appropriate services to SED children that a few other states have adopted is use of the 1915(c) Home and Community Based Services (HCBS) Waiver. The principle advantage of the HCBS Waiver is an increased flexibility in providing services, while at the same time heightening clinical and fiscal accountability.

Under a HCBS Waiver, the state could establish a new package of services for SED children who are either institutionalized or at risk of being institutionalized. For purposes of the waiver, an institution is considered to be an accredited inpatient psychiatric facility for children. SED

children who do not meet these criteria would still be eligible for services under the more traditional list of state plan services.

Waiver services can be individually tailored to the needs of the child and family and can be structured in a "wrap-around" manner that allows many more children to be served in the home, or in the community, without the need for institutionalization. Waiver services also bring the advantage of being far more predictable and controllable in terms of cost than services under a more traditional fee arrangement.

For Montana, structuring a HCBS Waiver could include engaging an independent, diagnostic entity to assist the Department in determining the SED diagnosis and whether a child meets the necessary level of care standard for the waiver. Local Kids management Authorities (KMAs) developed under Senate Bill 94, would serve as the gatekeepers into the waiver. Once a child was determined to be eligible for the waiver, qualified providers could be enlisted to develop a plan of care and cost plan, which would then be approved by the KMA. The KMA could also have an on-going role in monitoring the case and in quality assurance.

Given the fact that Medicaid is only one of many programs that may be involved in the care and treatment of an individual SED child, it is critical that the Department include a broad spectrum of providers, other local and state agency representatives, families and consumer advocates in the planning and development process. To accomplish this, the Department has created a work group composed of representatives of the above constituencies to assist the Department as it moves forward with the planning process.

The Department, in close consultation with the work group, has begun some preliminary work on how a HCBS Waiver might best be designed. The Department and the work group believe that a properly structured HCBS Waiver should offer the following benefits:

a. More flexibility in service design, and the opportunity to provide "what is really needed" rather than those services that are on a menu;
b. The ability to provide services not just to the child, as is the case under traditional state plan services, but to "wrap" services around the child and family together;
c. Greater ability to control costs by offering waiver services with a specific dollar cap and by serving children in the community at a lesser cost than institutional services;
d. The waiver can serve as an agent of change in helping to move the system to a more local and family-based focus; and
e. The waiver concept fits well with the development of the system-of-care concept adopted by the Montana Legislature.

Programmatically, an HCBS Waiver should have a major impact on the manner in which services are delivered to this population, and to the services they receive—making them more local, more specifically attuned to the needs of children and families, and more home and community focused. New service categories can be developed that will help children stay at home, and treatment services may be provided to families, not just to children. Families will be more in charge of directing their own services.

Fiscally, an HCBS Waiver should have a significant impact on stabilizing the cost growth of serving SED children in the higher ranges of acuity. While it is not expected to reduce overall program expenditures, the waiver should provide a new mechanism for cost control that is not available today.

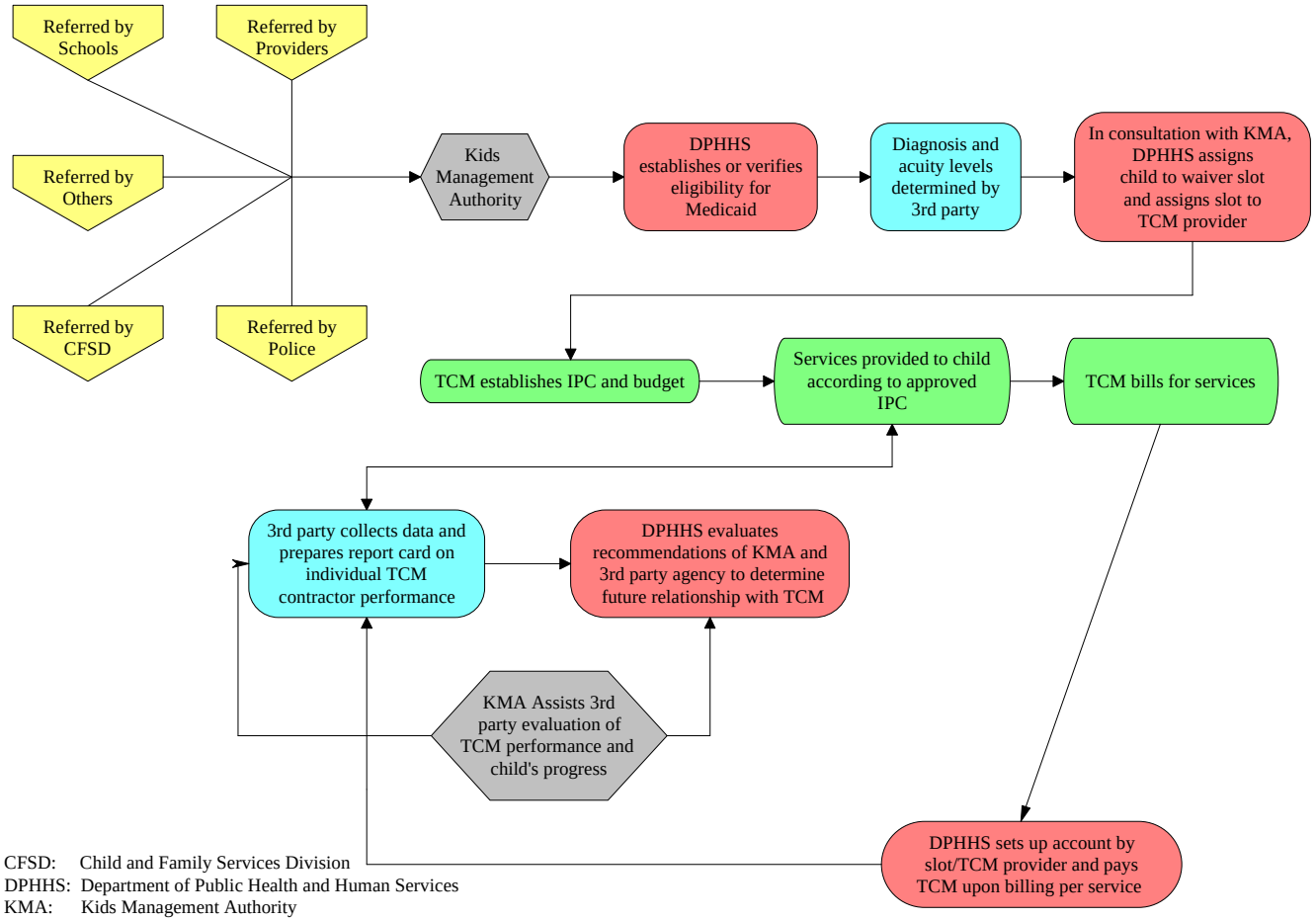
At its most recent meeting, the above-mentioned work group expressed support for the pursuit of an HCBS Waiver, and while many questions remain about the details of how the waiver might be structured, it is worth noting that there is a very high degree of unity between the Department, the providers, and the advocates regarding the merits of pursuing an HCBS Waiver for SED children.

Improve Services for Seriously Emotionally Disturbed Children

The Department should continue to consult with the established work group to develop a network of service delivery for seriously emotionally disturbed children (SED) that emphasizes direct support for children and their families, provides significantly enhanced flexibility of services, and contains expenditures within reasonable and predictable limits. To accomplish this, the Department is proposing a 1915c Home and Community Based Waiver, which would allow the state increased flexibility in providing services, while at the same time heightening clinical and fiscal accountability. As currently envisioned, such a new system would incorporate the following major components:

a. A 1915(c) Home and Community Based Waiver to allow enhanced flexibility of services within the context of directly supporting children and families with the goal of maintaining children in their families and communities;
b. Involvement of local Kids Management Authorities (KMA) in development and administration of the system;
c. Encouragement of culturally sensitive and appropriately trained mental health providers to provide services to Native Americans living on reservations or in urban areas with significant numbers of Native American peoples;
d. Integration of the legislatively adopted system of care concepts; and
e. Provision for enhanced accountability through third-party clinical evaluations of recipients and periodic third-party evaluation of provider performance based upon specific outcome criteria.

Figure 7
Flow of SED Services



1. CFSD: Child and Family Services Division
2. DPHHS: Department of Public Health and Human Services
3. KMA: Kids Management Authority
4. TCM: Targeted Case Management
5. IPC: Individual Plan of Care

Health Insurance Flexibility and Accountability Waiver

Background: HIFA is a new form of Medicaid waiver included under the existing 1115 Demonstration Waiver authority granted to the Center for Medicare and Medicaid Services (CMS), the federal agency charged with administering Medicaid. The purpose of HIFA is to encourage states to explore ways to expand private and/or public health-care coverage through creative proposals that go beyond the all or nothing approach that inhibits the use of Medicaid as a vehicle to address unmet health-care needs. HIFA places special emphasis on expanding health-care coverage to currently uninsured individuals with incomes under 200 percent of the federal poverty level.

While much of what HIFA does is theoretically available under the existing 1115 Waiver authority, the creation of the initiative, with its submission guidelines and expedited review process, sends a clear signal to the states that CMS is open to, and encouraging, proposals that increase the availability of basic health care through the use of unique benefits packages for existing and non-traditional Medicaid eligibility groups. While Medicaid law currently allows states to provide an extensive array of medical services to a wide variety of eligibility groups, it generally requires that each eligibility group receive all of the medically necessary services offered. Some of the key features of HIFA are the ability it gives to states to:

1. Design more limited benefit packages to meet the health needs of some eligibility groups (no more "all or nothing");
2. Require increased cost sharing for some eligibility groups (e.g. premiums and copays);
3. Limit or cap the state's financial obligation for services to some eligibility groups; and
4. Provide limited benefits packages through private insurance.

The Department believes that the HIFA Waiver program provides an opportunity for the state to refinance and strengthen an existing program, while reinvesting the savings to assist low-income Montanans who are currently uninsured to gain access to health-care services. The DPHHS proposal would fund the existing state Mental Health Services Plan (MHSP) under Medicaid and provides over $10 million dollars per year in health care to currently uninsured low-income Montanans. Because the HIFA waiver proposal will be reviewed by the Montana Legislature and subsequently will be subject to negotiations with the federal government (CMS), it is not possible to exactly define the populations that would ultimately be served or the specific allocation of new federal funds. However, the following provides a general scenario that the Department believes is a viable option that can serve as the basis for future discussion.

a. Continue funding for the current MHSP services that are provided to recipients who <u>do not have health insurance</u> with Medicaid;
b. Provide a Medicaid funded primary care health benefit of up to $500 per person per year that includes physician services, urgent care and emergency room care, for MHSP recipients who do not have health insurance;

c. Provide approximately $1 million per year in additional Medicaid funding for MHSP pharmacy and therapy services;
d. Provide mental health services for up to 300 SED children who are in transition to adult services from the children's services system;
e. Provide these same transitional SED children with a Medicaid funded primary care health benefit of up to $500 per person per year;
f. Provide the funding to enroll up to 5,000 additional children per year in the CHIP health-care program;
g. Fund a basic health-care benefit that includes some hospitalization and has an annual upper limit on expenditures (e.g. similar to Blue Care) for approximately 1,500 uninsured low-income working parents of Medicaid and CHIP children per year;
h. Allocate $250,000 in the Mental Health Block Grant to fund Service Area Authorities and/or the Adult System of Care;
i. Provide one-time funding in FY 2007 and FY 2008 to enhance/replace the Medicaid Management Information System;
j. At some point in the five-year life of the waiver, provide CHIP participants and Medicaid/CHIP parents with the option to enroll in an employer premium assistance program or to remain in their existing benefit program;
k. Maintain total general fund expenditures at the amount appropriated to MHSP in FY 2004; and
l. Require some form of enhanced cost sharing for HIFA waiver participants, including MHSP, based on their ability to pay.

Note: While not part of this HIFA Waiver proposal, the Department is committed to continuing to explore the potential to provide a prescription drug discount card to individuals ages 62 through 65, to be funded through Medicaid drug rebates.

Medicaid Eligibility

Background: Decisions regarding which groups of individuals should be eligible for the Medicaid program, the criteria used to determine eligibility, and the accuracy of the eligibility process can all have a considerable impact on the overall cost of the program. Unlike Medicare, which is a nationally administered program with universal eligibility criteria that are primarily age related, Medicaid is predominately a state-administered program with extensive financial requirements governing eligibility that are based on an individual's income and resources. Within certain federal guidelines, Medicaid allows states broad discretion in establishing their own eligibility thresholds for the program.

> *"Eligibility determination is the gateway to all of Montana's Medicaid program."*
>
> Hank Hudson, Administrator HCSD

To become Medicaid eligible under federal Medicaid statutes, an individual must fall within one of five broad categories: children; pregnant women; individuals with disabilities; adults in families with dependent children; or the elderly. In addition to meeting categorical eligibility, there are also financial eligibility criteria that must be met. Financial criteria are measured in two areas: income tests and asset (resources) tests. These financial tests vary from category to category and in some cases within categories. For example, the income and asset tests for the disabled are different from those for the elderly, and the income test for children under 6 years old is different from the income level for children 6-19 years old.

Both income eligibility and asset eligibility are composed of two separate components: an income (asset) **standard**, such as a percent of the federal poverty guideline or $3,000 limit on personal resources; and an income (asset) **methodology** for calculating what exactly constitutes the standard, such as what income sources are included or disregarded as part of the calculation of income, or disregarding the equity value in a car as part of the asset calculations.

A significant early step in the redesign process was a comprehensive analysis of all of the various options available to the Department to adjust Medicaid eligibility criteria (a complete list of the options is presented in Appendix 5. The list also includes eligibility changes specifically rejected by the advisory council and Department). Some options, such as elimination of the Medically Needy program, were quickly rejected as too devastating and clearly incompatible with the Department's stated goals of protecting the most vulnerable and needy. It also became apparent that Montana' eligibility criteria for income and assets were, in most instances, already fairly close to federally allowed minimums. However, there were also inequities in the manner in which the Department applied eligibility criteria across population groups and areas where the Department believes some restrictions would more accurately reflect the Department's goals and mission.

Implement Changes in Medicaid Eligibility

The Department supports the following changes to Medicaid eligibility criteria and processes because they are consistent with the policy goals of supporting personal responsibility, enabling effective and efficient program administration, and ensuring a sustainable Medicaid program into the future. The Department also believes that implementing these eligibility changes is reasonable and appropriate and would help contain Medicaid expenditure growth. While the limited amount of data available in some program areas makes it difficult to confidently project the exact savings associated with each option at this time, the Department is committed to the ongoing evaluation of the impact of these or any other eligibility changes that are implemented in order to document their impact on both people and expenditures.

1. EXTEND THE LOOK-BACK PERIOD FOR ASSET TRANSFERS TO 60 MONTHS

Background: To meet Medicaid eligibility requirements, individuals can simply transfer their assets to other family members. In order to discourage inappropriate use of the program, federal regulations allow states to determine whether an individual has transferred significant assets and to require a penalty period roughly equivalent to the value of the assets transferred measured against the average daily cost of nursing home care. During the penalty period, the individual is not eligible for Medicaid. In Montana, at the time an individual submits an application for Medicaid, the Department "looks back" 36 months to determine if there has been a significant transfer of assets. The obvious intent of such a policy is to make it more difficult to transfer assets and become eligible for Medicaid in anticipation of the need for nursing home care at some time in the future.

Medicaid eligibility staff are reporting increasing evidence that Montanans—often based on the advice of attorneys who specialize in Medicaid estate planning—are circumventing the asset transfer restriction by carrying out asset transfers beyond the 36-month look-back period. Other states are responding to this same phenomenon by seeking federal approval to extend the look-back period for asset transfers beyond 36 months (e.g. 60 months, 72 months or 120 months). Should Montana decide to pursue such a policy, it would require a federal waiver.

QUALIFYING FOR MEDICAID TO PAY NURSING HOME COSTS

"If you have already applied for Medicaid it's not too late to protect your assets."

Title and copy from law firm soliciting estate planning

Change in Eligibility: The Department should pursue a federal waiver to extend the look-back period to 60 months in order to further prevent people with significant resources from transferring assets solely for the purpose of becoming eligible for Medicaid. Since the Department does not currently collect data on asset transfers that occur prior to 36 months, it is impossible to project a precise amount of savings that would result from this change. However, the Department has attempted to assess the general impact of this policy option by surveying county eligibility staff regarding the prevalence of Medicaid estate planning, including asset transfers. The Asset Transfer Survey (Appendix 6, page 95) reported that there has been an increase in the number of calls and inquiries by attorneys and families involving financial

planning and asset protection for Medicaid eligibility. The survey also indicated that most applicants were aware of the 36-month look-back period on asset transfers and waited to apply for Medicaid when the look-back period had expired. Those who serve penalty months are often individuals who experience sudden unexpected medical problems that result in a need for nursing home care and who attempt to transfer assets inappropriately. Others serving penalty periods are individuals who transferred assets anticipating good health for the next 36 months but then faced unexpected medical problems. A 60-month look-back period would make it more difficult to transfer assets solely to qualify for Medicaid.

2. BEGIN ASSET TRANSFER PENALTY PERIOD IN THE MONTH OF MEDICAID APPLICATION

Background: Montana currently imposes the asset transfer penalty period beginning in the month that an unallowable asset transfer occurred, without regard to whether the person is in the nursing home and paying for his or her own care at that time. As a result of this policy, if an individual makes an unallowable asset transfer but does not immediately enter a nursing home, some or all of the penalty period can be met without the need to incur any actual expenses. If a person enters a nursing home after the penalty period has expired, he or she will be immediately eligible for Medicaid even though he or she has not paid for any of his or her own nursing home care.

"77% of adults have planned and saved for their retirement, while only 37% have saved any money to cover their expected long-term care costs."

Bob Bartholomew, Advisory Council Member

Montana could begin the penalty period on the date an individual applies for Medicaid-funded nursing home care, thereby ensuring that he or she actually has to purchase care equal to the value of the unallowable asset transfer. This policy change would require a federal waiver.

Change in Eligibility: The Department should seek a federal waiver to change the beginning of the asset transfer penalty period to the month of application. The Asset Transfer Survey (Appendix 6) illustrates that most nursing home applicants have already served their penalty periods before receiving nursing home benefits and therefore incur no expenses that could have been paid during the penalty period. By waiting to begin the penalty period at application, individuals would be responsible for paying for an estimated average of 8 months of nursing home care themselves rather than paying for it through Medicaid. In FY 2003, the average annual cost to Medicaid for a person in a nursing home was $30,532 (state and federal share). According to the Asset Transfer Survey, 74 individuals who applied for Medicaid during the six-month period from August 2003 to January 2004 had transferred assets and would have been ineligible under this proposed change.

3. SANCTION ADULTS WHO FAIL TO COOPERATE WITH THEIR TANF AGREEMENTS

Background: Currently, the cash benefits of TANF recipients who consistently fail to follow their TANF agreements are reduced, but the state allows those individuals and their children to retain their Medicaid eligibility. Montana could decide to eliminate Medicaid eligibility for TANF adults who fail to follow their TANF agreements but continue to maintain eligibility for their children. This would require a change in state law.

Change in Eligibility: The Department strongly supports the concept of individual responsibility that underlies this proposed change. However, because the Department believes that increased policy coordination between the TANF program and Medicaid is critically important, a significant policy change of this nature must be incorporated within the larger context of changes made within the TANF program. The Department no longer supports this option.

4. CLOSE CASES IMMEDIATELY AFTER THE 10-DAY NOTICE REQUIREMENT IS MET

Background: If the Department determines that individuals are no longer eligible for Medicaid, it is required to give them 10 calendar days written notice of their loss of eligibility and their right to appeal. Currently, Montana extends Medicaid eligibility to the end of the month in which the 10-day notification occurs. The unintended consequence of this policy is that, once individuals are notified that they will soon be ineligible, many use their remaining period of eligibility in that month to seek any medical treatment they feel they need or want (a.k.a. "slamming"). In some instances, this allows up to 40 days of additional Medicaid coverage.

Montana could decide to terminate Medicaid eligibility immediately after the 10-day notification period, thereby reducing the time frame during which allowable but discretionary medical expenses can be incurred. This policy change would require changes to state regulations.

Change in Eligibility: The Department should initiate changes in state regulation to close cases immediately after the 10-day notice requirement is met. Under the current policy, all Medicaid closures are now effective at the end of the month in which the notification occurs. Both service providers and Department eligibility staff have indicated that many Medicaid recipients are likely to use the remaining period of eligibility to seek additional discretionary medical treatment. It is appropriate that individuals who have been determined to be no longer eligible for Medicaid benefits should not be allowed to receive additional or continued benefits after a reasonable (10-day) notification period. Although it is difficult to estimate the potential savings that would accrue from such a policy change, the Department believes the change would be consistent with its goals of fiscal accountability and personal responsibility.

5. LONG-TERM CARE INSURANCE PARTNERSHIPS

Background: A strategy employed by many states to help control the rate of growth in Medicaid nursing home expenditures is to encourage individuals to purchase long-term care (LTC) insurance. The obvious intent of this policy is to give people greater control over their future and reduce the number of people who rely on Medicaid to fund their nursing home care. Since 1997, Montana has taken several steps to encourage the purchase of LTC insurance, including providing a state tax deduction for the full cost of any LTC insurance premiums paid on behalf of individuals or their spouse, parents or grandparents. A significant incentive contained in this policy initiative was enabling legislation that authorized the Department to develop a Long Term Care Insurance Partnership program if and when changes were enacted in federal law that would allow such insurance programs to occur in conjunction with the Medicaid program.

The purpose of a Long Term Care Insurance Partnership is to encourage individuals to purchase private long-term care insurance policies to provide for their potential long-term care needs. At the same time, the program would protect certain assets when individuals have exhausted their private long-term care insurance and have applied for Medicaid. Under Long Term Care Insurance Partnerships, individuals may qualify for special protection of their resources if they purchase a long-term care insurance policy certified by the commissioner of insurance and the Department prior to becoming eligible for medical assistance benefits. There are currently two Long Term Care Insurance Partnerships models.

1. Under the Dollar for Dollar model, Medicaid disregards an amount of an individual's resources in determining medical assistance eligibility by one dollar for each dollar paid out to the individual under the individual's long-term care insurance policy.

2. Under the Total Asset model Medicaid disregards all of an individual's resources in determining eligibility for medical assistance after all of the individuals long-term care insurance benefits have been exhausted under an insurance policy providing coverage for a specific length of time.

Four states—California, Indiana, New York, and Connecticut—currently operate Long Term Care Insurance Partnership Programs under a waiver from the federal government that "grandfathered" in their existing programs in 1993. Other provisions in federal law also adopted in 1993 make it much less attractive for other states to participate in Long Term Care Insurance Partnerships. However, the President's 2005 executive budget proposal includes a provision to modify the requirements in a way that will make Long Term Care Insurance Partnerships more feasible without the need to seek a waiver similar to the one granted to the four states now operating partnership programs.

Change in Eligibility: Although not technically a change in eligibility, the Department should pursue creating a Long Term Care Insurance Partnership program in Montana using the Dollar for Dollar model. The intent of the program would be to encourage individuals to purchase high quality long-term care insurance policies as an alternative to inappropriate Medicaid estate

planning that transfers or diverts assets to meet eligibility requirements. While any significant savings in Medicaid nursing home expenditures that might result from implementing an insurance partnership program would not be realized until well into the future, Department staff believe that an insurance partnership program would further stimulate the purchase of private long-term care insurance and eventually restrain the growth of long-term care expenditures within the Medicaid program.

Keys to ensuring the desired savings include 1) requiring that the insurance policies approved by the state provide sufficient coverage and benefits and 2) adopting the more conservative Dollar-for-Dollar model rather than providing unlimited protection of total assets. In addition to the potential for Medicaid savings, a successful Long Term Care Insurance Partnership program would reinforce the goal of individual responsibility and gives people greater control over their own care and services while simultaneously increasing their ability to pass on some portion of a lifetime of earnings to their families.

6. WAIVER OF DEEMING

Background: For the past 20 years, states have used Medicaid Home and Community-Based Services (HCBS) waivers to provide in-home support and other community services to the elderly and to children and adults with developmental and physical disabilities as alternatives to institutional care provided in nursing homes or Intermediate Care Facilities for the Mentally Retarded. Since 1982, Montana has operated a successful HCBS Waiver for individuals with developmental disabilities and another HCBS waiver for the elderly and individuals with physical disabilities. Currently, Montana does not have an HCBS waiver for people who are disabled due to mental illness. A quirk in the federal enabling legislation makes it extremely difficult to gain federal approval for HCBS Waivers serving children and adults with mental illnesses. To date, only four states have been approved for such waivers.

> "*The DD Home and Community Based Services (HCBS) Waiver is the most important vehicle we have in our system to assist individuals with developmental disabilities to become fully integrated into community life."*
>
> Joe Mathews,
> Administrator
> DSD

An eligibility policy option that is only available under the HCBS Waiver program is the "Waiver of Deeming" of parental assets and income when determining the Medicaid eligibility of a child served in the waiver program. Under this policy option, a child's Medicaid eligibility is based only on the individual child's personal assets and income. The income and assets of the parents are not considered, no matter how large or small they may be. HCBS Waiver regulations do not allow states to implement any additional cost-sharing requirements for parents whose children become eligible as a result of the Waiver of Deeming, irrespective of their income level, other than the cost sharing required of individuals determined Medicaid eligible through the non-waiver eligibility process.

A primary purpose of the Waiver of Deeming is to keep children at home and families intact, rather than creating false incentives for families to place their children into institutional settings or relinquish custody of their children to the state in order to secure Medicaid funding for the

children's care.

***Change in Eligibility*:** The Department should seek the required changes necessary to implement a Waiver of Deeming with cost-sharing provisions for Seriously Emotionally Disturbed (SED) children and other children with disabilities enrolled in Montana's HCBS Waivers. The Department strongly supports the existing Waiver of Deeming option that is currently in place for determining Medicaid eligibility for children with disabilities. At the same time, the Department is concerned about the equity of having one group of recipients (developmentally disabled) receiving preferential access to services over another (seriously emotionally disturbed children) based exclusively on their diagnosis. As the Department proceeds with the restructuring of services for SED children, a key component of the proposal is pursuit of an HCBS Waiver. If Montana secures an HCBS Waiver for SED children, the Department should include the option to adopt Waiver of Deeming for SED children.

An issue of additional concern to the Department is the fact that, under the Waiver of Deeming concept, relatively high-income families that legitimately could afford to pay a reasonable portion of the costs of care could escape any liability. Therefore, the Department should study the feasibility of program changes to allow reasonable cost sharing based on a family's ability to pay. Given the limits on Medicaid waiver resources and the relatively high income level of these families compared to other Medicaid recipients, the Department believes that a reasonable program of cost sharing, based on parents' ability to pay, may be appropriate for these families and will result in Medicaid savings. Any cost-sharing proposal should be applied equitably among waiver programs. Because HCBS are not entitlement programs, there are inevitably waiting lists of individuals needing services. The savings that result from increased cost sharing would remain in the respective HCBS programs and be used to provide additional services to reduce the number of individuals on waiting lists. A reasonable and thoughtful cost-sharing requirement, based on the ability to pay, should enhance fairness and equity among these publicly funded programs.

Native American Exemption

Background: The Indian Health Services (IHS), an agency within the U.S. Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. This mechanism for providing health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. As a result of this special government-to-government relationship, federal and state statutes, regulations and reimbursement structures for Medicaid services and reimbursement policies for Indian Health Services and tribal facilities have some provisions that are unique to the tribes and IHS. Funding for health-care services to Native Americans who are eligible for Medicaid and eligible to receive services directly from IHS or tribal facilities is paid for with 100 percent federal funds; the state is not required to provide a general fund match. However, under the terms of the agreement between the federal government, IHS, and tribes, 100 percent federal reimbursement is only available for those services allowable under the state's approved Medicaid State Plan. Thus, if a change is made by the Department or Legislature to the state plan to reduce services or restrict eligibility in an effort to save state general fund dollars, an unintended consequence is a corresponding reduction in 100 percent federally funded services by IHS and tribal facilities. Further compounding the problem is the fact that IHS and tribal facilities are required to continue providing the health-care services but must now provide such services with other funds. This results in a significant cost shift from 100 percent federal funds to either tribal funds or non-reimbursable IHS funding.

> *"The public needs to know there is NO general-fund cost for Medicaid services provided by tribal governments or IHS."*
>
> Garfield Little Light, Advisory Council Member

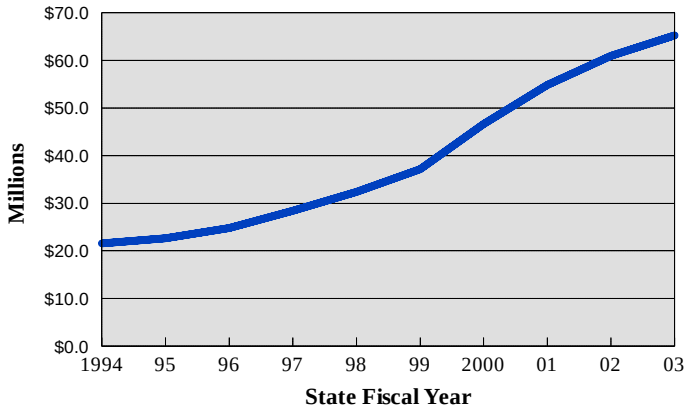
Seek Exemption for IHS and Tribal Health-care Facilities

The Department should—when possible, necessary, and appropriate under state and federal law or regulation—seek an exemption for Indian Health Services and tribal facilities from changes in eligibility categories, eligible services, and reimbursement levels under the Montana Medicaid program that could potentially result in a direct shift of costs from the 100 percent federal Medicaid reimbursement to direct costs to either Indian Health Services or tribally sponsored health-care services.

Containing the Cost of Medicaid Prescription Drugs

Background: Prescription drug coverage is an important optional service under the state Medicaid program. Over the last several years, Medicaid expenditure for prescription drugs has been the fastest growing sectors in the entire Medicaid program. As may be seen in Figure 8, in fiscal year 1994 Montana spent about $21.6 million for Medicaid prescription medications after federal rebates. In FY 2003, the state spent approximately $65.2 million after rebates, an increase of over 200 percent in nine years. The cost of drugs to the Medicaid program would be even more astounding if the federal government had not required drug manufacturers to provide drug rebates to the states. Montana currently receives a rebate of approximately 20 percent on total drug costs.

Figure 8
Medicaid Drug Expenditures



The rate of prescription growth is not unique to Montana's Medicaid program but is a national phenomenon that impacts all sectors of the health-care system. A number of factors have contributed to the rapid increase in Medicaid drug expenditures, including:

a. Increases in the Medicaid-eligible population;
b. Increased utilization of medications by recipients;
c. More expensive drug therapies;
d. New drugs that have come on the market;
e. Inflationary drug price increases; and
f. A significant increase in direct-to-consumer advertising.

Clearly the current rate of growth in the Medicaid prescription drug program expenditures cannot be sustained into the future. In recognition of this fact, the Department has instituted a number of procedures to contain spending, while continuing to provide this critical service to Medicaid-eligible people in need of medications. Such actions include:

a. Drug Rebates: Montana participates in the Medicaid Drug Rebate Program, created by the federal Omnibus Budget Reconciliation Act of 1990. The law requires that manufacturers enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to provide rebates for their drug products that are paid for by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for federal Medicaid coverage of their product(s). The annual amount of Montana's drug rebate is

substantial and equal to about 20 percent of our total annual Medicaid expenditures for drugs.

b. Formulary/Prior Authorization: The federal government mandates that the Medicaid prescription drug program continually evaluate new drugs and drug use patterns and implement restrictions to access of drugs through a prior authorization program. Many drug products require prior authorization before the pharmacist provides them to the client. Requests are reviewed to make sure they meet the medically necessary criteria.
c. Drug Utilization Review: In 1992, Montana implemented both prospective (at the time of dispensing) and retrospective reviews of drug use. Under prospective reviews, the claims payment system ensures that Medicaid recipients cannot fill the same prescription at different pharmacies and cannot refill a prescription before they use up at least 75 percent of the previously dispensed amount. The prospective system also warns the pharmacist of potential drug interactions, high or low doses, and therapeutic duplications. Retrospective reviews are carried out by the Drug Utilization Review Board, which is composed of three physicians and three pharmacists. They examine drug regimens and drug use patterns and contact prescribers when potential problems are revealed.
d. Mandatory Generic Use – Since July 2001, prescribers and pharmacies must prescribe and dispense the generic form of a drug whenever possible. If a brand-name drug is prescribed instead of a generic equivalent, the prescriber must get prior authorization. Authorization is based on medical need, such as adverse reactions (clinically demonstrated, observed and documented) that have occurred when the generic drug has been used.
e. Lower Dispensing Limitations: In February 2003, Medicaid reduced the amount of a drug that can be dispensed at one time. Medicaid recipients are now routinely limited to a 34-day supply of a drug. Prescriptions may be refilled after 75 percent of the estimated therapy days have elapsed. Early refills are authorized for dosage changes or when individuals are admitted to a nursing home.
f. Increased Cost-Sharing: In July 2002, the Department increased prescription drug co-payments for Medicaid recipients, with the exception of children, pregnant women, and people in nursing homes. Recipients pay between $1 and $5 dollars per prescription based on 5 percent of the Medicaid allowable up to a $25 cap per month.
g. Increased Tab-splitting: In some cases, a lower-dose tablet of certain medications costs the same as a higher-dose tablet. If the tablet can be easily scored and split, dispensing the higher strength and instructing members to split the tablet allows cost savings. Medicaid has implemented tab splitting for Zoloft 100mg.
h. Pharmacy Case Management: In October 2003, the Department implemented a provider-centric model of case management for identified Medicaid clients.
i. Pharmacy Audits: In November 2003, the Department issued an RFP to evaluate and monitor the Medicaid Prescription Drug Program through invoice pharmacy audits and on-site visits.

While the Department has taken a number of important steps to contain growth in pharmacy costs, the Medicaid drug program continues to grow at an unsustainable rate.

Implement Additional Pharmacy Cost-containment Measures

In addition to the actions taken to date, the Department is exploring other actions that are intended to restrain the growth in Medicaid prescription drug expenditures:

a. The Department should evaluate efforts under way in other states and, in cooperation with CMS, assess the options for participation in re-importation of drugs from other countries;
b. The Department should explore the feasibility of establishing a state-sponsored drug discount program; and
c. Pending further review and consideration, the Department should implement one or both of the following alternatives:

i. Alternative One: Implement a Preferred Drug List/Supplemental Rebates. A number of states have developed a single-state or in some cases a multi-state Preferred Drug List (PDL). The PDL identifies selected drug classes that have a reference drug identified by clinical and best price analysis. The preferred drugs are available to prescribers without prior authorization. All other medications within the drug class continue to be available to Medicaid clients but require prior authorization. Once a preferred drug has been chosen by a formulary committee, drug manufacturers who wish to have their drug included on the list of medications not requiring prior authorization, i.e. inclusion on the PDL, must meet the reference drug price either by a price reduction or supplemental rebates. Drug prices and supplemental rebates would be negotiated and administered by a contracted pharmacy benefits administrator who uses multi-state pooling power to get the best price and rebates from drug manufacturers. Supplemental rebates in other states have averaged between 7 and 10 percent of the total amount of their Medicaid expenditures for drugs. Montana Medicaid is also considering an evidence-based medicine contract to assist in the clinical decision-making process. The PDL would not impact the reimbursement rate to pharmacy providers. In November 2003, Montana issued a Request For Proposal to assess the feasibility and costs of developing a Montana PDL. The Department initiated a PDL program on July 1, 2004.

ii. Alternative Two: Increased Co-payment for Equally Effective Higher-Cost Drugs. This proposal would impose a significantly higher co-payment for a drug when a less expensive and equally effective alternative is available. The alternative would have to be considered as effective as the higher-cost drug as determined by a contractor or the Drug Utilization Review Board. This policy would encourage appropriate use of prescription drugs by Medicaid-eligible individuals. The change would require a contractor or the Drug Utilization Review Board to assess all prescription drugs available under the Medicaid program and identify effective, lower-cost alternatives. For example, Prilosec OTC might be considered an alternative to Nexium. Since Prilosec OTC is the lower-cost alternative, the Medicaid program could require a large co-pay for the purchase of Nexium. The co-pay amount on the Nexium could be set at a high percentage (such as 50

percent) with no monthly co-payment cap. The physician would be given the opportunity to establish medical necessity for the Nexium through the prior-authorization process. Alternative Two would have to be developed in conjunction with the preferred drug list option. Non-preferred drugs would have higher co-payments than preferred drugs within the same therapeutic class. This option would encourage clients to make the same rational choices that individuals with private insurance or in private-pay status have to make. This policy change would also require a waiver from the federal government.

At the request of individual tribes or the IHS, the Department should also explore mechanisms, including a 1915(b) Freedom of Choice Waiver, to insure that IHS-eligible Medicaid participants on reservations have their prescriptions filled at IHS or tribal facilities.

Family-planning Waiver

Background: Nearly half of all public dollars for family-planning services and supplies in the United States are spent through the Medicaid program. Under this very important source of family-planning support, the federal government and the states share the cost of serving eligible individuals. The federal government contributes $9 for each $1 that states spend on family planning—a significantly higher federal match than is available for other Medicaid-funded care.

During the past several years, 18 states have sought and received federal permission to provide Medicaid-financed family-planning services and supplies to lower-income, uninsured residents whose incomes are above the state's regular Medicaid-eligibility ceilings or who do not meet existing eligibility criteria. States have taken two approaches to expanding eligibility for Medicaid-covered family-planning services and supplies. The first approach, started by Rhode Island and South Carolina in 1993, built directly on the Medicaid expansions for pregnant women to continue Medicaid coverage beyond the regular 60-day postpartum period. This approach extended the time during which postpartum women could access family-planning services. More recently, some states have taken a different approach by seeking to extend Medicaid family-planning coverage to women and men who had not previously been covered under Medicaid or other state programs.

Montana initially considered developing a Section 1115 Family-planning Waiver in 1999 to extend family-planning services to women and men at or below 200 percent of the federal poverty level. Such low-income individuals whose income and resources are above the regular Medicaid eligibility criteria are unlikely to have either insurance coverage or sufficient personal funds to purchase family-planning and reproductive-health services in the private sector. They are therefore at higher risk of unintended pregnancy and in need of family-planning services. A family-planning waiver assumes that eligible women and men, if given access to low or no cost contraceptive and reproductive health-care services, will prevent or delay pregnancy. Thus, they will delay the potential for becoming eligible for Medicaid because they are pregnant or medically needy.

Montana did not submit a waiver in 1999 because federal legislation was introduced that would have given states authority to expand Medicaid family planning without going through the federal waiver process. The initial bill did not pass, despite continued efforts to move the process forward. Therefore, under current regulations, states are required to submit a waiver in order to expand family-planning services beyond their current Medicaid-eligible population.

Section 1115 of the Social Security Act permits the Secretary of the U.S. Department of Health and Human Services to waive certain portions of the federal Medicaid Act for a five-year demonstration project if the project is budget neutral to the federal government. Using the Section 1115 Waiver process, the state has several options to retain control over the degree of expansion and the costs including:

a. Accessing federal Medicaid funds to cover expansion populations who would otherwise not qualify for the program, including low-income adults who are single or who have grown children;
b. Offering a restricted package of benefits, rather than the full Medicaid benefits, to a targeted expansion population;
c. Capping enrollment or creating a time-limited program to avoid an open-ended entitlement; and
d. Setting enrollment caps for the expansion population and use of beneficiary cost-sharing measures (e.g., deductibles, co-payments, and premium contributions) to help reduce waiver expenditures.

Under a demonstration waiver, Montana could provide family-planning services statewide for five years. Covered services could include office visits, limited laboratory services, sterilization and contraceptive devices, and pharmaceutical supplies. Eligible women and men could obtain family-planning services from any qualified Medicaid provider. Such providers would include physicians, nurse midwives, nurse practitioners, federally qualified health centers, hospital clinics, and pharmacies. In addition, All Title V and Title X family-planning clinics would be eligible to provide services under the demonstration project.

Explore Feasibility of Submitting Family-planning 1115 Waiver

The Department should explore the feasibility of submitting a Section 1115 Waiver for the purpose of expanding family-planning services. The primary goal of the Montana family-planning demonstration project would be to reduce Medicaid costs by decreasing unintended pregnancies and births to women who potentially may become Medicaid recipients through pregnancy-related eligibility criteria. These costs include prenatal care, delivery, and medical costs for the mother, and ongoing health care for the child. The specific objectives of the waiver could include:

a. Increased use of family-planning services among low-income women (and men) who are not currently eligible for Medicaid;
b. Reduced rate of unintended pregnancies and births among Montana females, including teenagers, with incomes at or below 200 percent of the federal poverty level;
c. Decreased number of women who become eligible for Medicaid because of pregnancy and then have a subsequent birth within two years;
d. Support of other family-planning programs under Title V and Title X by allowing more of these funds to be used for outreach and education, as well as for more affordable services to other clients between 200 and 250 percent of the federal poverty level; and
e. Coordination with other state and community groups to implement a Montana plan to prevent adolescent pregnancy and to increase awareness of the need for family-planning services and the effects of unintended pregnancies.

Transportation Brokerage

Background: The Department spends approximately $2.1 million per year on non-emergency medical transportation services covered by Medicaid. Transportation is provided for individuals needing assistance in getting to and from doctor and dentist appointments, dialysis, and non-emergency outpatient care. In an effort to save money, improve access, and increase efficiency of transportation services, many state have instituted transportation brokerage systems. Although there is considerable variation among the various brokerage models, the fundamental theory behind each is that, by better coordination of providers and service users, significant savings can be realized through reductions in fraud and abuse, ride sharing, and use of the most appropriate transportation modalities. Because access to transportation is also a significant barrier for many other human-services programs, some states have applied the transportation brokerage services across several different programs, such as disabilities programs, adult and aging programs, and work programs. States have also been able to partner with other non-state agencies, such as insurers and local non-profit human-service providers.

Although transportation brokerages are easier to establish in urban areas, both Washington and Oregon, which also have large rural areas to cover, have managed in improve transportation services in the more sparsely populated areas of their states. In Washington, nine regional brokerage agencies are contracted to provide transportation services to 13 separate regions. By using the brokerage system, the Washington Medicaid program estimates it has reduced the average cost per trip from $60 to $17 statewide.

Under the transportation brokerage model, when a Medicaid recipient needs non-emergency transportation, the recipient calls the transportation broker, who verifies Medicaid eligibility and determines what method of transportation is most appropriate and least expensive in the particular instance. Depending on the client's needs, the broker can use a variety of resources, such as volunteers, transit buses, mileage reimbursement, and shared taxi rides. Providers are paid for each ride based on a pre-arranged fee.

Explore Feasibility of Implementing Transportation Brokerage System

Based on the recommendation of the Council, the Department should review the feasibility of implementing a pilot transportation brokerage program for a selected region of the state. Based on the results of the review, the Department could implement a transportation brokerage pilot project in selected areas of the state. In addition to cost factors, the Department should also assess the quality, timeliness, and accessibility of transportation services.

Codifying Legislation

Background: Unfortunately, the general fate of reports such as this is a relatively short shelf life. Administrators, legislators, and bureaucrats inevitably come and go, and the normal course of events leads to changes in the social, economic, and political environment within which the Medicaid program operates. Therefore, if the Medicaid Redesign Project is to have a meaningful impact, some mechanism should be put in place to institutionalize its critical aspects. As noted at the beginning of this report, a primary objective of the project was to articulate a set of fundamental values that could be used to guide policymakers in making decisions. The legislative process is the appropriate vehicle for additional public discussion and adoption of a set of core values that can be incorporated as Montana's formal declaration of the objectives and purpose of the Montana Medicaid program.

It is also important to identify a mechanism to insure the continuity of those aspects of the redesign project that deal with administrative procedures and issues, such as contained in the Council's recommendations on funding priorities, reimbursement principles, and management principles. At the same time, administrative processes must be allowed the flexibility to adapt as technologies change.

Develop Codifying Legislation

Recognizing the need to formally establish continuity in policy development and management procedures employed by the Department and Legislature, the Department should seek an amendment to a section of Title 53, Chapter 6, MCA, during the 59th Legislature that will incorporate the following as fundamental core values and principles of the Montana Medicaid program:

- When considering changes in policy or reduction in services, the Department and Legislature should first protect those most vulnerable and most in need as defined by the combination of the severity of their economic, social, and medical circumstances.
- When considering changes in policy or reduction in services, preference should be given to eliminating an entire Medicaid program or service rather than sacrificing the quality of care for several programs or services through dilution of funding.
- When considering changes in policy or reduction in services, priority should be given to retaining those services that protect life, alleviate severe pain, and prevent significant disability.

Additionally, the Council has recommended that the Department seek an amendment to MCA 53-6-110 (Report and Recommendations on Medicaid Funding) requiring the Department to include in its biennial report to the Legislature a chapter that provides specific reference to the following Council recommendations as included in this report:

a. Recommendation # 2 Funding Principles;
b. Recommendation # 3 Management Principles;
c. Recommendation # 4 Reimbursement Principles; and
d. Recommendation # 5 Third-party Liability.

Future changes to the above recommendations would be maintained and updated through the Medicaid Advisory Council established under federal CFR 42 and reported as a required component of the biennial report to the Legislature.

APPENDICES

Appendix 1:
House Joint Resolution 13

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING THAT THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES CONDUCT A STUDY REGARDING THE HEALTH PROGRAMS ADMINISTERED BY THE DEPARTMENT AND PROVIDE A REPORT TO THE 59TH LEGISLATURE, OUTLINING OPTIONS THAT MAY BE UNDERTAKEN TO REDESIGN THE HEALTH PROGRAMS ADMINISTERED BY THE DEPARTMENT.

WHEREAS, rising health care costs, expanded use of services, and increased enrollment in the Montana Medicaid program, the Mental Health Services Plan, the state Children's Health Insurance Program, and other health programs administered by the Department of Public Health and Human Services have resulted in escalating costs to the State of Montana; and

WHEREAS, expenditures in the Montana Medicaid program for the 2002-03 biennium are projected to be $1,071,000,000, which includes $267 million in general fund money and $804 million in federal funds; and

WHEREAS, expenditures in the Mental Health Services Plan for the 2002-03 biennium are projected to be $20,507,133 in state general fund money; and

WHEREAS, expenditures in the state Children's Health Insurance Program for the 2002-03 biennium are projected to be $28,967,574, which includes $5,472,768 in state general fund money, $882 in state special revenue funds, and $23,493,934 in federal special revenue funds; and

WHEREAS, expenditures in the Montana Medicaid program, the Mental Health Services Plan, and the state Children's Health Insurance Program constitute a significant portion of the state general fund; and

WHEREAS, federal regulations limit the discretion that states have in the administration of the Medicaid program; and

WHEREAS, federal regulations mandate that certain health care services be provided and that certain groups be automatically eligible for Medicaid; and

WHEREAS, federal regulations do permit the Secretary of the U.S. Department of Health and Human Services to grant waivers of certain federal requirements; and

WHEREAS, federal regulations and the Centers for Medicare and Medicaid Services require three formal consultations with tribal governments regarding any major changes within the existing Medicaid program and related programs; and

WHEREAS, the State of Montana recognizes the seven federally recognized Indian tribes in Montana, and the Legislature directs the Department of Public Health and Human Services to recognize and include the seven federally recognized tribal governments in Montana within all aspects of a Department study; and

WHEREAS, upon participation of the seven federally recognized Indian tribes in Montana, the Legislature directs the Department of Public Health and Human Services to include the seven tribal governments in any aspect of the study and include the recommendations and participation in the report to the Legislature; and

WHEREAS, it is essential that the Legislature as a whole be informed about the alternative approaches that may be undertaken and that the Legislature set the policy regarding the design of the Montana Medicaid program, the Mental Health Services Plan, the state Children's Health Insurance Program, and other health programs administered by the Department of Public Health and Human Services.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Department of Public Health and Human Services direct sufficient staff services to undertake a study that will examine the various options available for redesigning the Montana Medicaid program, the Mental Health Services Plan, the state Children's Health Insurance Program, and other health programs administered by the Department.

BE IT FURTHER RESOLVED, that the Department of Public Health and Human Services report on a regular basis to the Children, Families, Health, and Human Services Interim Committee and to the Legislative Finance Committee regarding the progress of the study.

BE IT FURTHER RESOLVED, that the Department of Public Health and Human Services prepare a report to the 59th Legislature, as provided in section 5-11-210, MCA, detailing various

options available for the redesign of the Montana Medicaid program, the Mental Health Services Plan, the state Children's Health Insurance Program, and other health programs administered by the Department. This report should include the costs, both economic and social, associated with various options for redesign of these programs and a cost analysis for urban Indian health clinics and tribal-based health clinics.

BE IT FURTHER RESOLVED, that the Secretary of State send a copy of this resolution to each tribal government located on the seven Montana reservations and to the Little Shell Band of Chippewa.

- END –

Appendix 2:
Executive Order Creating Public Health Care Advisory Council

EXECUTIVE ORDER CREATING THE
GOVERNOR'S PUBLIC HEALTH CARE ADVISORY COUNCIL

WHEREAS, the State of Montana has a responsibility to ensure access to basic health care services for Montanans most in need; and

WHEREAS, rising health care costs, expanded use of services, and increased enrollment in the Montana Medicaid program, the Mental Health Services Plan, the state Children's Health Insurance Program, and other health programs administered by the Department of Public Health and Human Services have resulted in increased costs to the State of Montana; and

WHEREAS, federal regulations limit the discretion that states have in the administration of the Medicaid program, and mandate certain health care services be provided and specific groups automatically eligible for Medicaid; and

WHEREAS, states have the authority to apply to the Secretary of the U.S. Department of Health and Human Services for waivers of certain federal requirements; and

WHEREAS, Montana's seven federally recognized American Indian tribes play a critical role in the development of health care policy in Montana, and

WHEREAS, it is essential that the Legislature be informed about alternative approaches to make public policy decisions regarding the design of the Montana Medicaid program, the Mental Health Services Plan, the state Children's Health Insurance Program, and other health programs administered by the Department of Public Health and Human Services.

NOW, THEREFORE, I JUDY MARTZ, Governor of the State of Montana, by virtue of the authority vested in me pursuant to the Montana Constitution and the laws of the State of Montana, do hereby create the Governor's Public Health Care Advisory Council (the "Council"), in accordance with the provisions of Section 2-15-122 and 2-15-102(8), MCA, for the purposes set forth below.

1. PURPOSE:
   The purpose of the Council shall be to assist and advise the Governor and the Department of Public Health and Human Services (the "DPHHS") on public policy issues. Further, the Council shall work in concert with DPHHS to fulfill the requirements of House Joint Resolution 13 passed during the 2003 Montana Legislature. Specifically, the Council shall advise the Governor and the DPHHS on issues including, but not limited to:

1. Advise in the preparation of a report outlining various options for the Medicaid program--to include the Mental Health Services Plan, the state Children's Health Insurance Program, and other health programs administered by the Department.
2. Advise in regard to study updates on a regular basis to the Children, Families, Health, and Human Services Interim Committee and to the Legislative Finance Committee. Such information should include costs (economic and social) associated with various options for redesign of these programs and a cost analysis for urban Indian health clinics and tribal-based health clinics.

2. COMPOSITION:
The Council shall be comprised of not more than 18 members who shall serve at the pleasure of the Governor. The names and addresses of the members are to be submitted to the Secretary of State.

3. ADMINISTERING AGENCY:
The DPHHS is designated as the organizational unit responsible for the administration and management of the Council.

4. DURATION:
This Executive Order is effective immediately and shall remain in effect until December 31, 2004, unless extended or terminated by subsequent Executive Order.

GIVEN under my hand and the GREAT SEAL of the State of Montana, this _____ day of 2003.

_____ATTEST:

JUDY MARTZ, Governor

BOB BROWN, Secretary of State

Appendix 3:
Public Health Care Advisory Council Membership

Name	Primary Interest	Organization Affiliation
Ask, Tanya	Insurance	Blue Cross Blue Shield of Montana
Bartholomew, Bob	Long-term Care, Senior Citizens	Montana AARP
Blouke, Peter	DPHHS	DPHHS
Caferro, Mary	General Public, Low-income Women	WEEL
Clark, Edith	Legislature	House
Costigan, Twila	Medicaid Consumers, Foster Care	Intermountain Children's Home
Hermanson, June	Disabled, Medicaid Consumers	Independent Living Council
Hughes, Rose	Long-term Care, Senior Citizens	Montana Health Care Association
Hurwitz, Dan	Legislature	House
Kirn, Rick	Native American Health Care	
Kasten, Betty Lou	General Public	Former Montana Legislator
Kiser, James	Hospitals	St. James Community Healthcare
Keenan, Bob	Legislature	Senate
Little Light, Garfield	Native Americans, IHS	Indian Health Services
Marks, R.D.	Physicians, Nursing	Western Montana Clinic
Mihelish, Gary	Mental Health, Dental	National Alliance for Mentally Ill
Schmidt, Trudi	Legislature	Senate
Soft, Loren	Mental Health, Chemical Dependency	Yellowstone Boys and Girls Ranch
Vargo, Patsy	Rural Health, Physicians	Montana Medical Association
Windy Boy, Jonathan	Native Americans, Legislature	House

Appendix 4:
Native American Subcommittee Membership

Name	Tribal Membership/ Organization
Bighorn, Ernest	Indian Development & Educational Alliance, Inc.
Chandler, Carol	Fort Belknap
Chandler, Craig	Fort Belknap
Failing, Mary	Indian Development & Educational Alliance, Inc.
Howlett, Kevin	Confederated Salish & Kootenai
Irvine, Lloyd	Confederated Salish & Kootenai
Kennedy, Nora	Blackfeet
Lavenger, Ed	Little Shell
Little Light, Garfield	Indian Health Service
Lott, D.J.	Indian Family Health Clinic
Peterson, Myrle	Fort Peck
Real Bird, Mallory	Crow
Scofield, Marian	Indian Development & Educational Alliance, Inc.
Snell, Jade	Crow
Watson, Renita	Rocky Boy

Appendix 5:
Complete List of Eligibility Options

DPHHS POSITION ON
POTENTIAL CHANGES IN MEDICAID ELIGIBILITY

ELIGIBILITY CHANGES DPHHS SUPPORTS

The Department of Public Health and Human Services supports the following changes to Medicaid eligibility criteria and processes because they are consistent with the policy goals of supporting personal responsibility and effective and efficient program administration and ensuring a sustainable Medicaid program into the future. The Department believes that implementing these eligibility changes is reasonable and appropriate and will help contain Medicaid expenditure growth. While the limited amount of data available in some program areas makes it difficult to confidently project the exact savings associated with each option at this time, the Department is committed to the ongoing evaluation of the impact of these or any other eligibility changes that are implemented in order to document their impact on both people and expenditures.

Option 1: Extend the look-back period for asset transfers beyond 36 months: The Montana Medicaid eligibility staff reports increasing evidence that people—often based on the advice of attorneys who specialize in Medicaid estate planning—are circumventing the asset transfer restriction by carrying out asset transfers beyond the 36-month look-back period. Other states are responding to this same phenomenon by seeking federal approval to extend the look-back period for asset transfers beyond 36 months (e.g. 60 months, 72 months or 120 months). The obvious intent of such a policy is to make it more difficult to transfer assets and become eligible for Medicaid in anticipation of or based on the fear of the need for nursing home care at some time in the future. Should Montana decide to pursue such a policy, it would require a federal waiver.

> **DPHHS position:** The Department supports pursuing a federal waiver to extend the look-back period to 60 months in order to further restrict the ability of people with significant resources to transfer assets solely for the purpose of becoming eligible for Medicaid. Since the Department does not currently collect data on asset transfers that occur prior to 36 months, it is impossible to project a precise amount of savings that would come as a result of this change. However, the Department has attempted to assess the general impact of this policy option by surveying county eligibility staff regarding the prevalence of Medicaid estate planning, including asset transfers. The Asset Transfer Survey (attached summary) reported that there have been an increased number of calls and inquiries by attorneys and families involving financial planning and asset protection for Medicaid eligibility. The survey also indicated that most applicants were aware of the 36-month look-back period on asset transfers, planned accordingly, and waited to apply when the look-back period had expired. Those who do serve penalty months are often individuals who experience sudden unexpected medical problems that result in a need for

nursing home care and then attempt to transfer assets inappropriately, or individuals who transferred assets anticipating good health for the 36-month period but who then face unexpected medical problems. A 60-month look-back period would make it more difficult to anticipate the need for Medicaid and make transfers solely to qualify for Medicaid.

Option 2: Begin the asset-transfer penalty period in the month of Medicaid application: The penalty period for unallowable asset transfers is computed by dividing the amount of the unallowable transfer by the average monthly cost of nursing home care to a privately paying individual. The logic and intent behind the penalty period is that people should pay for their own nursing home care in an amount equal to the value of the assets they have transferred inappropriately. Montana currently imposes the penalty period beginning in the month that an unallowable asset transfer occurred, without regard to whether or not the person is in the nursing home and paying for his or her own care at that time. As a result of this policy, when individuals who make unallowable asset transfers do not immediately enter a nursing home, they may be able to meet all or some of the penalty period without incurring any actual expenses. When individuals apply to a nursing home after the penalty period has expired, they will be immediately eligible for Medicaid even though they haven't paid for any of their own nursing home care. Montana could decide to begin the penalty period on the date of application for Medicaid-funded nursing home care, thereby ensuring that the individual actually had to purchase care equal to the value of the unallowable asset transfer. This policy change would require a federal waiver.

DPHHS position: The Department supports seeking a federal waiver to change the beginning of the asset-transfer penalty period to the month of application. The recent Asset Transfer Survey illustrated that most nursing home applicants have already served their penalty periods before receiving nursing home benefits. Therefore, they incur no expenses that would have been paid during the penalty period, as intended. By waiting to begin the penalty period at application, an estimated average of eight months of nursing home care would be the responsibility of the individual rather than a cost to Medicaid. In FY 2003 the average annual cost to Medicaid for a person in a nursing home was $30,532 (state and federal share). According to the Asset Transfer Survey, 74 individuals have applied in the past six months who had transferred assets in way that would have resulted in ineligibility under this proposed change.

Option 3: Sanction adults who fail to cooperate with their TANF agreements: Currently, the cash benefits of TANF recipients who consistently fail to follow their TANF agreement are reduced, but the state allows those individuals and their children to retain their Medicaid eligibility. Montana could decide to eliminate Medicaid eligibility for TANF adults who fail to follow their TANF agreements, but continue to maintain eligibility for their children. This policy change would require a change in state law.

DPHHS position: The Department no longer supports this option to seek a change in state law to revoke the Medicaid eligibility of adults who consistently fail to follow their TANF agreements. People who sign TANF contracts and then fail to meet the terms of

the contracts are in breach of those contracts. Denying Medicaid benefits to these adults until they comply with the requirements of their contracts makes the TANF program more like the work environment experienced by most employees. The Council believed there should be clear and meaningful consequences for failing or refusing to cooperate with TANF requirements. Many families can get by with one month of a reduced grant (the cash amount for one person is removed when a sanction is imposed). The loss of Medicaid coverage for the adult, in addition to the reduction in the cash payment, may provide more incentive to cooperate if it means their Medicaid coverage will be reinstated once they comply. In no case will an adult's failure to comply with a TANF agreement result in a child's loss of Medicaid benefits. Currently there are 145 people per month whose cash benefits are sanctioned because they failed to follow their TANF agreements. The average monthly Medicaid expenditure for a TANF adult is about $300.00. The Department is concerned about unintended consequences and no longer supports this option.

Option 4: Close cases immediately after the 10-day notice requirement is met: If the Department determines that someone is no longer eligible for Medicaid, it is required to give the individual 10 calendar days written notice of his or her loss of eligibility and the right to appeal. Currently, the state extends the person's Medicaid eligibility in such cases to the end of the month in which the 10-day notification occurs. The unintended result of this policy is that people who are notified that they will soon be ineligible may use their remaining period of eligibility in that month to seek any medical treatment they believe they need or want (a.k.a. "slamming"). Montana could decide to terminate Medicaid eligibility immediately after the 10-day notification period, thereby reducing the time frame during which allowable but discretionary medical expenses can be incurred. This policy change would not require a federal waiver

DPHHS position: The Department supports the option of closing cases immediately after the 10-day notice requirement is met. Under the current policy, and due to computer system limitations, all Medicaid closures are now effective at the end of the month in which the notification occurs. In some instances, this allows up to 40 days of additional Medicaid coverage. Due to input from both provider and Office of Public Assistance staff, the Department knows that Medicaid recipients are likely to use the remaining period of eligibility to seek additional discretionary medical treatment, (a.k.a. "slamming"). We are currently gathering the data necessary to prepare a more precise estimate of the fiscal impact of this option, but at this point we assume that eliminating the "rest of the month" coverage would result in some level of decrease in Medicaid expenditures. Modification of the Department's current computerized eligibility system to accommodate this change would be very expensive. Therefore, the implementation of this policy option will likely have to await the replacement of that system. Planning for the replacement is now under way.

Option 5: Increase quality control and quality assurance for Medicaid eligibility determination: The federal government requires states to conduct "pilot projects" that examine in detail single components of the Medicaid eligibility determination process, but they do not require states to implement comprehensive quality assurance systems to verify the overall

accuracy of Medicaid eligibility decisions. Consistent with the federal requirement, Montana has conducted federally required pilot projects in the past, such as a review of nursing-home resource determination processes and decisions. However, the state has not implemented a comprehensive internal quality-assurance system to review Medicaid eligibility determination across the state, largely due to a lack of resources. While there is no evidence of a significant error rate in the Montana Medicaid program, there are no hard data from which to draw a conclusion one way or the other about the overall accuracy of eligibility decisions in the state. Montana could decide to implement an ongoing internal quality-assurance system for Medicaid eligibility-determination decisions. This policy change would not require a federal waiver but would require additional funding to implement such a system.

> **DPHHS position:** The Department supports a proposal to implement a Medicaid eligibility quality-assurance system and is incorporating it into a broader proposal to enhance the consistency and effectiveness of Medicaid eligibility determination. This proposal will be presented to the Council.

ELIGIBILITY CHANGES DPHHS OPPOSES

The following eligibility options were presented to the redesign council as potential changes. However, both the Department and the redesign council opposed these options to Medicaid eligibility criteria and processes. Several of the options, while clearly having the potential to reduce expenditures, may present too great a risk to the health and welfare of the recipients they would impact to be justifiable at this time. The costs of implementing and administering some of the other options appear to be greater than any savings they might produce.

Option 6: Reduce the medically needy income standard: The medically needy income standard is the amount of money that non-institutionalized individuals in the medically needy eligibility category are allowed to retain for their ongoing non-medical living expenses. Any income above that level must be used to pay for medical care in order to become eligible for Medicaid. For example, Montana's medically needy income level for a household of one is currently $525 per month, compared to a federal minimum of $350 per month. Montana could decide to lower the medically needy income standard, thereby increasing the amount of money an individual must spend on medical care but decreasing the amount of money available for other living expenses. This policy change would not require a federal waiver.

> **DPHHS position:** The Department is opposed to reducing the medically needy income standard. The people served through the medically needy program generally have a history of work but have developed a need for significant amounts of medical services due to an accident or illness or as a result of aging. These are people who earned wages in the past and now must "spend down" their monthly income to pay for medical services until only $525 remains for all other living expenses. By way of contrast, the monthly payment standard for SSI recipients (many with limited work history) is set by the federal government at $564. Within their $525 monthly budget, people in the medically needy program must find a way to pay for rent, food, clothing, utilities, transportation, and other

normal living expenses. Lowering the income standard to $392 per month would reduce Medicaid expenditures by requiring almost 4,000 people in the medically needy program who live outside of nursing homes to spend an additional total of almost $4 million per year on their own medical care. Expecting a group consisting of the elderly and people with disabilities, who also have a substantial need for medical care, to live on $392 per month is neither fair nor realistic. Faced with the reality of being unable to afford the basic necessities of life and the likelihood of deteriorating medical conditions, many of these people would have no option but to enter or be forced into a nursing home, offsetting some or all of the potential savings to Medicaid. Others might decide to forego medical care and continue to live in their own homes, despite the considerable risk to their basic health and well being.

Option 7: Compute medically needy spend-down based on eligibility spans of more than one month: Montana currently computes the incurment (spend-down) amount for each medically needy individual based on one month's income. The state could increase the number of months' income on which the incurment is based, thereby increasing the amount that must be spent on medical care before an individual becomes eligible for Medicaid. This change would make it harder for individuals to become eligible for Medicaid for a single month by accumulating (storing up) smaller medical expenses across a number of months in order to meet their incurment. This policy change would not require a federal waiver.

DPHHS position: The Department opposes the option to compute the medically needy spend-down based on more than one month's income. The following typical example illustrates the reason DPHHS opposes this option:

Currently, an individual with an income of $900 per month has a one-month incurment of $355. He or she can choose to take $355 from the monthly check to directly pay $355 in medical expenses (like an insurance deductible) or make a $355 "cash option" lump sum payment to the Department (like an insurance premium). He or she would then receive a Medicaid card for that month to pay for any remaining medical care. Under a three-month eligibility span, this same person could not use the cash option to make a lump-sum payment to the state, because a three-month incurment would be $1,065, more than the individual's monthly income. The person would have only two real choices: either leave Medicaid entirely in an attempt to live without the necessary medical care, or incur some medical bills and then not pay the medical service providers (recipients are required to incur medical bills but not necessarily to pay them). The later strategy will work only as long as medical providers do not demand payment at the time of service.

While this change would impact almost 4,500 people in the medically needy program, those people with small monthly incurments and stable medical expenses would likely be able to adjust to a three-month eligibility span. Many others would face the same desperate choices described in the previous example: delay or forego necessary medical care or find a benevolent medical provider willing to deliver medical goods and services now in the hope of payment (and at risk of non-payment) at some point in the future. Those who choose to restrict their medical care could see their health deteriorate, very

likely forcing them to enter a nursing home to receive services, with a corresponding increase in costs to Medicaid. While the Department cannot accurately predict the Medicaid savings resulting from moving to a three-month eligibility span, it is clear that most savings would result from two unacceptable scenarios: unpaid service providers or recipients foregoing necessary medical services.

Option 8: Count cash assistance as income: Montana does not currently count the TANF cash assistance benefit as income when determining Medicaid eligibility. Counting TANF cash assistance as income would make some portion of TANF recipients ineligible for Medicaid. This policy change would not require a federal waiver.

DPHHS position: The Department opposes counting cash assistance as income. When this option was originally discussed, the TANF cash assistance income limits were considerably higher than the Family Medicaid income limits. In 2003, when the TANF cash assistance limits were reduced to 30 percent of the 2002 federal poverty level, this option became far less viable because only very large households (those with 15 or more members) would be impacted. Since there are currently no families this large receiving both TANF and Family Medicaid, the cost of upgrading the computer system to implement this option would far outweigh any potential savings.

Option 9: Reduce the Family Medicaid resource limit: The resource limit is the maximum amount of countable assets/resources that a person may have in order to become eligible for Medicaid. Countable resources do not include a person's primary residence or vehicle, but they do include things such as cash, non-residence property, second vehicles, and recreational vehicles. Federal law allows states to set a Medicaid resource limit of no lower than $1,000 for people in the Family Medicaid eligibility categories. Montana's Family Medicaid resource limit is currently $3,000. The state could decide to lower the limit from the current level to the federal minimum, or somewhere between the two, thereby forcing people to reduce their countable resources or lose Medicaid eligibility. This policy change would not require a federal waiver.

Note: Montana is already at the federal minimum resource limit for aged and disabled individuals living in the community ($2,000 for an individual and $3,000 for a couple). The state has also adopted the minimum resource level allowed by the federal government under the Medicaid "spousal impoverishment" provisions, which enable the spouse of a person residing in a nursing home to retain additional assets and income.

DPHHS position: The Department opposes reducing the resource limit for Family Medicaid. Currently, only 262 families on the Family Medicaid caseload (3 percent) have countable resources in excess of $2,000. Approximately 800 families have countable resources over the $1,000 minimum. The Department believes that implementing a lower resource limit would produce little or no savings to Medicaid. A significant percentage of the resources above $1,000 are non-cash items such as second cars, which can be given away or sold without penalty. Cash resources above $1,000 can quickly be spent on other non-countable items such as food, clothing, and furniture. Given that one of the primary goals of the TANF program is to foster and encourage self-

sufficiency, allowing families to accumulate a little savings is a reasonable policy. It provides a small cushion for families in the event of unemployment or any other emergency. If we did not allow families this small cushion, they would be more likely to request TANF cash or emergency assistance when an unforeseen event occurs. It would also prove a hindrance to families wishing to move, because they would never be allowed to accumulate enough savings to cover a deposit and first and last months' rent payments.

Option 10: Reduce the Section 1931 income limits (percent of poverty level): The Section 1931 Medicaid eligibility group consists of families who, prior to federal changes in August 1996, were automatically eligible for Medicaid because they received cash assistance through the Aid to Families with Dependent Children (AFDC) program. In 1996, a change in federal law removed the link between AFDC and Medicaid. As a result, these families must now qualify for Medicaid under a separate Medicaid determination. When the federal law changed in 1996, states were required to base their Section 1931 income limits on the state's July 16, 1996, AFDC income standards. These income standards could then be increased by the Consumer Price Index on an annual basis. Montana has not increased its Section 1931 income limits since July 1, 2001. States are allowed to lower their Section 1931 income limits, but not below the AFDC income limits effective in the state on May 1, 1988. Montana could decide to lower its Section 1931 income limits from its current levels to the minimums allowable under federal law, or somewhere in between. If we reduced income limits to the 1996 levels, the limit for a family of three would decrease from $491 to $425 per month. If the family had countable income that exceeded this amount, they would not be Section 1931 eligible. The children would most likely be eligible under another Medicaid program, but the adults would not be eligible for Medicaid unless they were aged, blind, or disabled. This policy change would not require a federal waiver.

DPHHS position: The Department does not support lowering the Family Medicaid poverty level. The Family Medicaid income limits are already set very low (27.6 to 37.8 percent of the 2004 federal poverty level), and they have not been increased since July 2001. At the current standards, a family of three can have no more than $491 in countable income per month, and a family of six can have no more than $789 per month. Reducing the income limits to 25 percent of the federal poverty level would deny Medicaid to approximately 700 adults at a projected initial savings of $2.5 million per year. While the intent of such a policy might be to encourage adults to become self-sufficient, the unintended outcome might be to require families to become further impoverished so that the adults could get Medicaid. Almost two-thirds of the current Section 1931 caseload has no countable income. Do we really want to deny medical care to adults in the TANF program who may be generating at least a modest amount of income by working?

Option 11: Apply asset-transfer penalties to all Medicaid eligibility groups: The limitations and penalties related to asset transfers are currently only applied to Medicaid nursing home, or HCBS Waiver, applicants or recipients. While this may be the group that has made use of the transfer of assets in order to achieve Medicaid eligibility most often in the past, the potential for the same kind of inappropriate asset transfers exists for other Medicaid eligibility groups as well. Montana could decide to apply the same asset-transfer requirements to all Medicaid applicants and recipients without regard to their specific eligibility category. When an unallowable asset

transfer occurred during the look-back period, the state would calculate and impose the same kind of penalty period that is currently required in nursing homes. While the method of calculating the length of the penalty period would be different from the one now used in nursing homes, the intent would be the same: require that people who have the resources to pay for their own care do so. This policy change would require a federal waiver.

> **DPHHS position:** The Department opposes applying asset-transfer limitations to Family Medicaid. This group is composed primarily of young families (single or two-parent households who are either unemployed or employed part-time) that simply have not had either the time or the resources to accumulate assets. While applying the asset-transfer policy to this group might be possible through a federal waiver, it would result in an increasingly complicated application process and very little if any savings to the Medicaid program.

Option 12: Reduce the age limit of all family-related eligibility groups to 19: States have an option to choose the age limits of children who may receive Medicaid. States can choose to cover children under age 18, under age 19, under age 20, or under age 21. Montana currently has only three children's Medicaid programs that allow coverage beyond the month of the child's 19th birthday. These are non IV-E foster or adoptive children and certain institutionalized children. Children in these three categories may be eligible for Medicaid through the month of their 21st birthday. Reducing the age limit on these programs to match the limit on all other children's Medicaid programs (which is currently under age 19) would make Medicaid coverage for children equitable across all programs. This policy change would not require a federal waiver, but it would require a state plan amendment.

> **DPHHS position:** The Department does not support reducing the age limit for all Family Medicaid-related groups to 19. Eligibility staff have identified only seven children above age 18 who are currently receiving Family Medicaid. Four of these children have adoption subsidies that guarantee Medicaid until age 21. Children eligible under these programs are typically medically and emotionally fragile, with significant medical needs, often resulting from abuse or neglect by their birth parents. Allowing these children to maintain Medicaid coverage as a child up to the age of 21 allows more time for the family to prepare the child to become an adult. It also allows time for Social Security applications and appeals processes while the child still has medical coverage.
>
> Reducing the age limit for subsidized adoption children could result in fewer hard-to-place children being adopted, because guaranteed Medicaid coverage helps to ensure adoptive parents that they will not be bankrupted by their new son's or daughter's medical needs.

ELIMINATED FROM CONSIDERATION BY COUNCIL AND DEPARTMENT

The following eligibility options, which were originally identified by the Public Health Care Advisory Council, have been eliminated from further consideration by both the Council and the Department.

Option: Eliminate the medically needy program: Removed from the list by DPHHS in January 2004.

Option: Cap the vehicle equity exclusion amount: Eliminated from consideration based on recommendation of the Council at February meeting.

Option: Reduce coverage during the second six months of Transitional Medicaid: Eliminated from consideration based on recommendation of the Council at February meeting.

Option: Provide a different benefit package to the medically needy: Eliminated from consideration based on recommendation of the Council at February meeting.

Appendix 6:
Asset Transfer Survey Summary

Questions to be answered by every worker who sees adult Medicaid applicants:

1. Within the past 6 months, how many applicants have you seen who have transferred assets that would have made them ineligible? Result: **74**

   For each applicant counted above, give the estimated value of the transferred assets:

   Summary of Results

   Average Transfer: **$52,000**
   Range: **$800 to $500,000**
   Total transferred in past six months: **$3,828,600**

2. In your opinion, what percentage of people serve their asset transfer penalties (whether the penalty included months after initial application or the penalty expired prior to Medicaid application) during periods of time during which they were NOT residing in a nursing home?

   None (0%): **5%** Few (1-25%): **35%** Some (26-50%): **22%** Many (51-75%): **20%** Most (76-100%): **18%**

3. In your experience, what is the average length in months of an asset transfer penalty period that is served by an individual during a period of time that the individual is NOT in a nursing home?

   Average Number of Months: **8 months**

4. Here is a list of frequent methods of asset transfers or attempts to transfer. Please rank them in the order of how often you see them used.

   Gifts: **1**

   Contracts for exchange of property for services (sometimes verbal or backdated): **2**

   Trusts: **3**

   Below-value sales: **4**

   Annuities: **5**

5. Additional comments on asset transfers:

"I have had clients come in after they have transferred farms---this is after the 36 months has expired."

"The average client does not have that many assets. They are the ones that gift items away or sell for below value. If there are funds to be used up before they are eligible, it only takes 3 to 6 months. People who have large sums of money or property usually put them in a trust."

"Most large transfers seem to be done more than 3 years prior to application."

"Most common resource transfer----homes to children over 36 months before application."

"The public seems to be better educated about transfers."

1. How often does your county receive questions from members of the public, including family members of potential applicants, financial planners, lawyers, CPAs, etc., regarding rules surrounding asset transfers and Medicaid eligibility?

Daily: **5** Weekly: **15** Monthly: **10** Annually: **5**

2. In your opinion, has the frequency of asset transfers and inquiries about asset transfers increased or decreased within the past 5 years? Increased: **18** Decreased: **4**
Have inquiries been more or less frequent in the last year? More: **14** Less: **5** Stayed the same**: 4**

3. How many asset transfer periods do you calculate in your county within an average month? **2 is the average; ranged from 0-6**

4. What is the average length of the asset transfer penalty periods calculated? **8 months**

5. Additional comments on asset transfers:

"It seems people are learning ways around it and doing the transfers earlier. Documentation is difficult to get."

"Most calls/visits I get are from family members re: how to protect resources."

"I do not think the OPA's are aware of most transfers."

"We are finding some clients aren't reporting asset transfers and we are accidentally finding out about them…. We spend a lot of time trying to track them and find out what occurred."

"Calls are generally from attorneys."

"In most cases the look-back and/or penalty period has already passed."

"Overall comment from staff, these don't occur very often. In the case of large transfers, most families have consulted with an attorney and then wait three years before applying for Medicaid."

"I am seeing an increase of people transferring all assets and waiting out the three-year period. Some of these people are currently in the nursing home and have a three-year long-term care policy; a like number have not entered the nursing home."

Appendix 7:
Characteristics of Seriously Emotionally Disturbed Population

The following information on the characteristics of Seriously Emotionally Disturbed (SED) children was derived from a fiscal year 2003 MMIS data extract of Medicaid expenditures for all mental health services provided to individuals meeting the state's criteria of SED. Severely Emotionally Disturbed children are defined in the Administrative Rules of Montana (ARM) as children with a primary diagnosis from a specific group of mental-illness diagnoses and exhibiting certain behavioral characteristics. Because the current MMIS system does not track recipients by major disability (i.e. mentally ill, developmentally disabled, physically disabled, etc.), it is possible that some SED children are not included in the data extract and that some individuals who meet the diagnostic criteria are included but may not meet the behavioral or age (6-17) criteria. However, despite these shortcomings, the data contained in this report are adequate to provide a synopsis of the general characteristics of Montana's Medicaid-eligible SED children.

A total of 8,330 children were identified as meeting the diagnostic criteria of SED. Of that number, 4,706 (57 percent) were male and 3,624 (43 percent) were female. The age distribution of SED children is presented in Figure 1 on page 101. As may be seen from this chart, the age distribution is fairly even from ages 7 to 16, peaking at age 12. Also, it is important to note the number of individuals who meet the diagnostic criteria of SED but fall outside of the ARM-defined age range of 6 to 17. A total of 924 individuals between the ages of 18 and 21 continue to receive Medicaid mental health services and have a primary diagnosis consistent with serious emotional disturbance. Because there is some overlap in the definitions used to determine SED in children and Seriously Disabling Mental Illness (SDMI) in adults, it is possible that at least a portion of these individuals have transitioned from the children's mental health system to the adult mental health system. However, for the majority of SED children, the diagnostic and behavioral criteria in the adult SDMI system are different, and the transition from children's mental health services to adult mental health services is difficult if not impossible.

Figure 2 (see page 101) presents the distribution of the 10 most frequent primary diagnoses of SED. Almost 18 percent of SED children have a primary diagnosis of Attention Deficit Disorder with accompanying Hyperactivity. The second most frequent diagnosis is Oppositional Disorder. Of significance in the distribution of diagnoses is the fact that the three most frequent diagnoses as represented in Figure 2 are not recognized as part of the diagnostic criteria for adult SDMI or for SED without an accompanying more serious secondary diagnosis. Thus, by virtue of the diagnosis of their primary mental illness alone, 46.5 percent of the SED children would not transition to adult SDMI services.

Figure 3 (see page 102) shows Medicaid expenditures by major service categories. Of the total expenditure of $48,504,729, Residential Treatment Centers, Therapeutic Group Homes, and Therapeutic Foster Care accounted for $29,444,219 (61 percent). Residential care represents a major portion of the total mental health cost for SED children. Of the total expenditure for

residential care, $1,771,716 (6 percent) is spent on out-of-state facilities. The vast majority of residential care is provided in Montana.

Figures 4 (see page 102) provides information about the costs of individual recipients. It shows that just 5 percent of the SED recipients account for 51 percent of the total SED mental health expenditures. Ninety percent of SED mental health expenditures were spent on just 25 percent of all children diagnosed as SED. Data included in the analysis showed that 17 children cost in excess of $100,000 per year per child. Two hundred and twenty children cost between $50,000 and $99,000 per year per child. The high cost of services to the relatively small percentage of the population is primarily due to the cost for high-end residential care (residential treatment centers, therapeutic group homes, and inpatient hospital care). However, the above analysis includes only Medicaid costs. Not included in the analysis are the significant costs born by other public and private agencies that also interact with SED children, such as the school and juvenile justice systems.

Figure 1
Age Distribution of SED Children

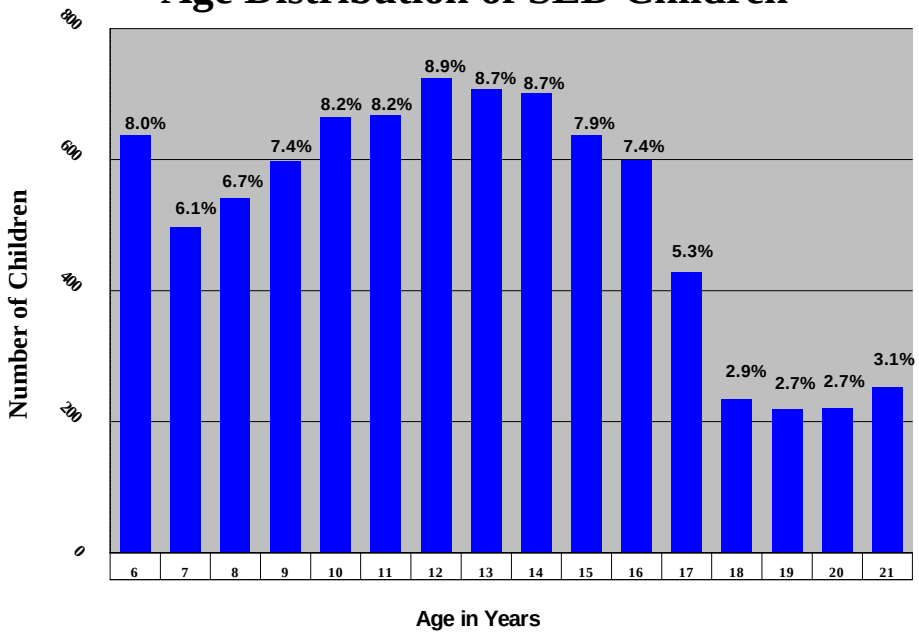


Figure 2
10 Most Frequent Diagnoses

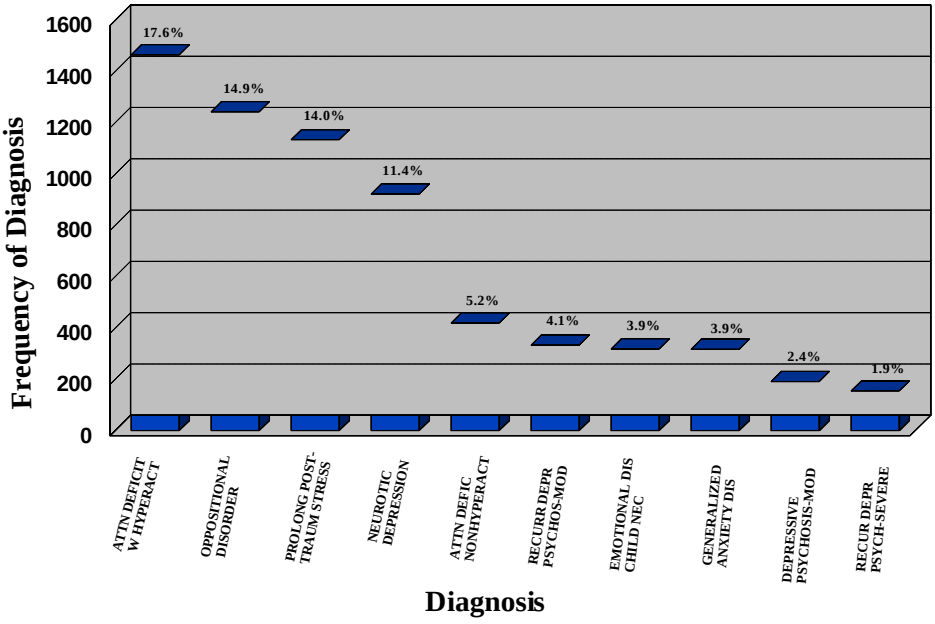


Figure 3
Expenditures by Major Service Category

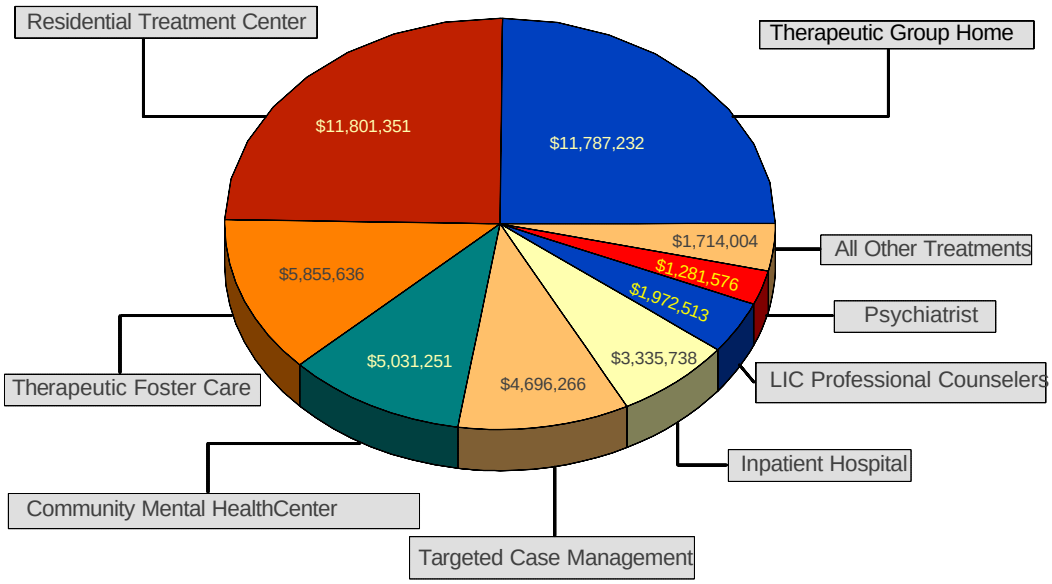
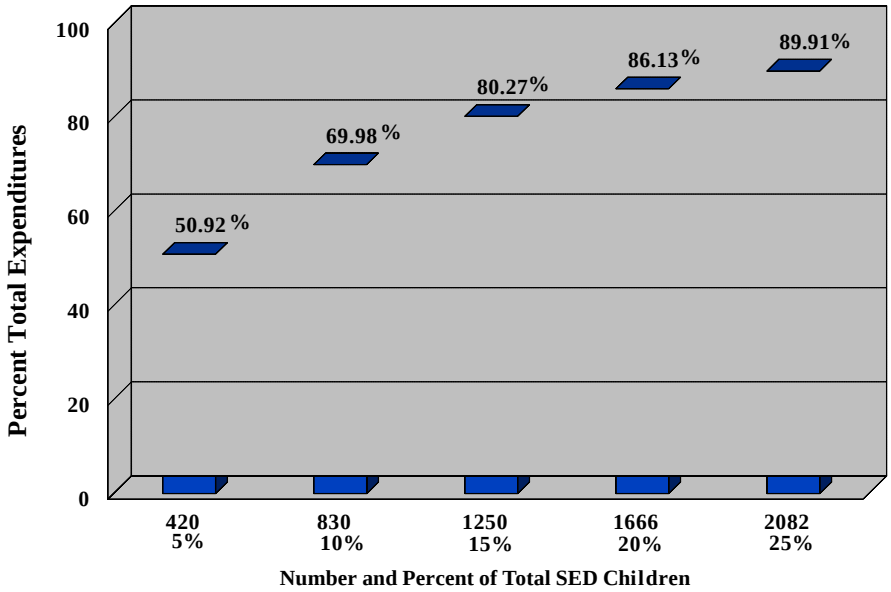


Figure 4
Percent Expenditures by Percent of SED Recipients



Appendix 8:
Characteristics of Mental Health State Plan Population

The following is a description of the general characteristics of the Mental Health State Plan (MHSP) population. The data were derived from the state Medicaid Management Information System for the period July 1, 2003, through September 30, 2003 (the first quarter of state fiscal year 2004). Although the sample is limited in time, it should present a relatively accurate snapshot of the characteristics of the population served and the services provided. A survey of the community mental health centers yielded some additional data on recipients seen by the centers during FY 2003 (see page 104).

The MHSP is a program designed to provide mental health services, including pharmaceutical services, to individuals who meet the state's criteria for Severe and Disabling Mental Illness (SDMI), as defined by diagnosis and functioning level, but who do not meet the financial or categorical eligibility standards for Medicaid. Participants can have incomes no higher than 150 percent of the federal poverty level. MHSP is funded through a combination of state general fund and federal community mental health block grants. For fiscal year 2004, the program has a total appropriation of $6,834,380.

Table 1 presents the number of recipients per month and the number of claims filed per month.

Table 1
Recipients and Claims Per Month

	Recipients	Claims
July 2003	2,052	6,499
August 2003	2,054	6,514
September 2003	2,002	6,149
Average	2,036	6,387

As the table indicates, the average number of recipients over the three-month period was 2,036, and the average number of claims filed in a month was 6,387. During this same time period, 2,710 different individuals received services. Of those 2,710 individuals, 1,503 (55.6 percent) were female and 1,207 (44.4 percent) were male. The breakdown by age groups is presented in Figure 1 (see page 106). The figure shows that the majority of the MHSP caseload (approximately 74 percent) is in the 26-55 age range. Relatively few are in the 65+ age group and also eligible for Medicare. The oldest recipient was 86 years old, and there were another five recipients over 80. The youngest recipient was 12 years old, and nine recipients were between the ages of 12 and 15.

Geographically, the MHSP population is fairly well distributed across the state and corresponds to the distribution of the general population. Based on recipient zip code information, there was a proportionate representation of urban and rural areas.

Under an agreement with the four regional community mental health centers (CMHC), the bulk of the funding for the MHSP flows through the centers. The primary exception is expenditures for pharmaceuticals, which go to private pharmacies throughout the state.

A survey conducted by the community mental health centers yielded the following information on some additional demographics of the MHSP population:

Table 2
CMHC Survey of MHSP Population

	Total	Percent
Number of MHSP Recipients Included	3,357	100%
Recipients on MHSP One Year or Longer	1,825	54.37%
Recipients Applying for Medicaid	597	17.8%
Recipients Transitioning from Montana State Hospital	121	3.6%

The above data does not include all of the MHSP population, because a small percentage just receives drugs and may not process through the CMHC system. However, for those clients using the CMHC system, the data is informative. As Table 2 indicates, a total of 1,825 (54 percent) of the recipients have been on the MHSP program for over one year. A relatively small percentage (3.6 percent) is transitioning from the state hospital. What is not evident from the above data is the percentage of individuals who experienced a psychiatric inpatient episode. Other information from the survey indicated that approximately 18. Eight percent of the MHSP population actually has private insurance, and another 11.6 percent is eligible for Medicare. Thus, 32 percent of the total MHSP population currently has some form of health insurance.

Figure 2 (see page 106) presents the MHSP expenditures by major provider group. A total of $1,191,904 (62 percent) of the total MHSP funding goes to the community mental health centers. Another major portion of the MHSP funding, $672,203 or 34.8 percent, is spent on drugs. A relatively small amount goes to private mid-level practitioners, psychiatrists, and hospitals. Of the total amount expended by the CMHCs, $584,760 (49 percent) was spent on case management with the balance for various treatment modalities.

Figure 3 (see page 107) presents the types and amount of services received by MHSP recipients. Under the general category of "treatment" are included such services as day treatment, individual and group therapy, group home care, medication management, psychiatrist services, physician services, and evaluations. As Figure 3 indicates, a significant percentage (47 percent) of recipients only received a single type of services and 28 percent only received treatment services, although they may have received a number of such services. Four hundred and ninety recipients

(18 percent) received multiple services, including drugs, case management, and some form of treatment. One hundred and sixty-one recipients (6 percent) received only case management services.

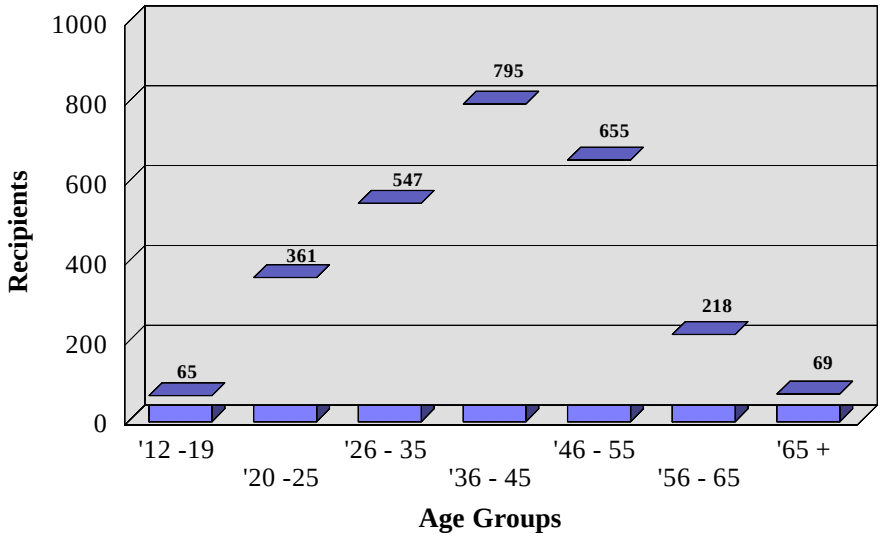
The chart in Figure 4 (see page 107) presents the cost per recipient. Cost per recipient ranged from a low of $4.45 to $14,335. The average cost per recipient for the 90-day period was $711.84, and the median cost $389.10. The high cost for some recipients, those exceeding $10,000, is primarily due to a combination of group home care, day treatment, and significant drug costs. Given the fact that, by definition, these are all individuals who must meet behavioral criteria for serious disabling mental illness, it is somewhat surprising that the average cost per recipient is so low. Additionally, Figure 3 shows that the mix of services received is also surprisingly bare, with a high percentage of recipients simply receiving "treatment only."

Further analysis of the distribution of services is presented in Figures 5 and 6 (see page 108). Figure 5 shows the number of treatment sessions per recipient. As may be seen from this chart, 1,259 (71 percent) of those recipients receiving a treatment service—individual or group therapy, day treatment, rehabilitation and support services, psychological testing, etc.—only received from one to five sessions. The average number of sessions was eight, but the median number is one. In other words, half of the individuals receiving any form of treatment during the 90-day period only received one session. Figure 6 presents the distribution of case management sessions per recipient. Again, as may be noted from the chart, the majority of recipients received relatively few sessions, which may have been all they required to maintain their circumstances.

Another area of major expenditure is pharmaceuticals. Figure 7 (see page 109) presents the distribution of drugs per recipient. As the chart shows, claims per recipient for medication during the 90-day period are relatively low, with 65 percent receiving one to five prescriptions. Because there is a relatively low turnover in the MHSP population, it is quite possible that in many of these cases the recipients are on an established medication routine and simple get periodic 90-day refills. The average cost per recipient for medication was $381.50, and the median cost was $276.70.

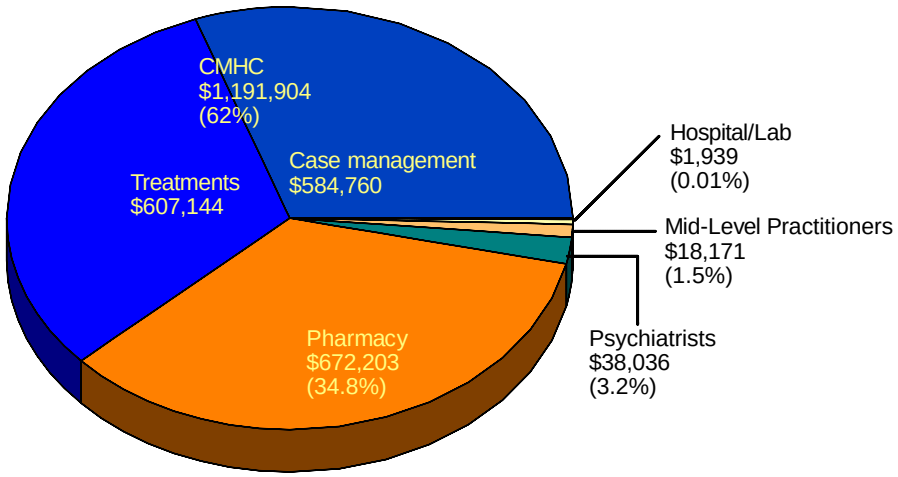
A far more extensive analysis of the MHSP population would be required before definitive conclusions could be made or specific recommendation offered for changes to the program. However, assuming the 90-day sample of the MHSP population is generally reflective of the overall population of MHSP recipients, some general observations can be made. As could be predicted, the MHSP population appears to be fairly stable in terms of its need for long-term care and treatment. However, it also appears from this limited sample that, for the majority of recipients, relatively few clinical interventions are required to maintain them in the community. A few individuals do require a high level of support and frequent clinical interventions. Overall, the cost of care to maintain these individuals in their homes and communities is low compared to the costs the state would incur if even a small percentage deteriorated to the point that they required institutional care at the state hospital.

Figure 1
MHSP Population by Age Group



Data from 1st Quarter Fiscal 2004

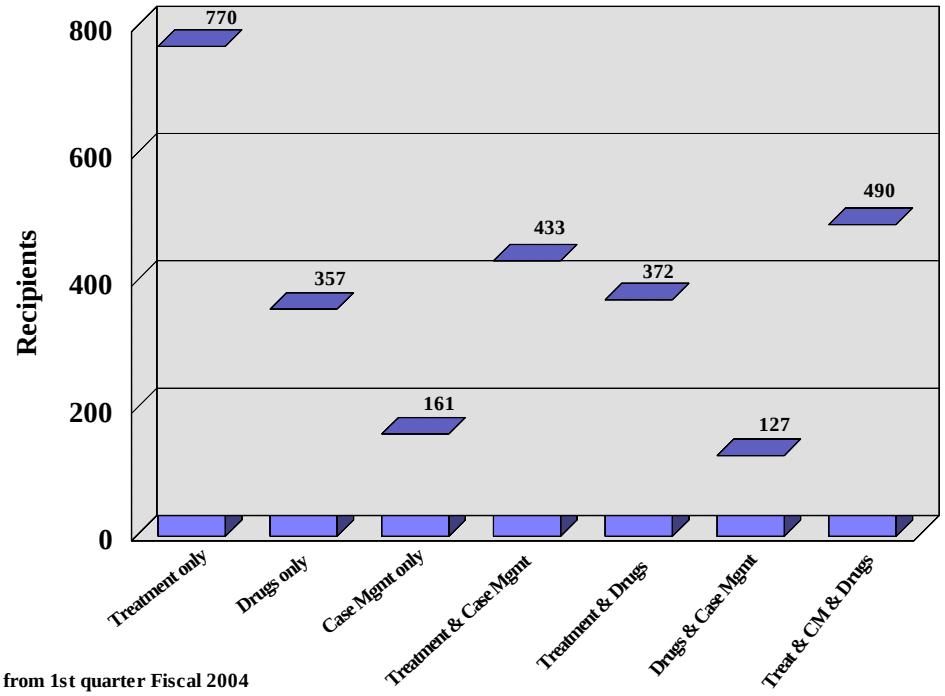
Figure 2
MHSP Expenditures by Provider Group



Total Expenditures
$1,929,081

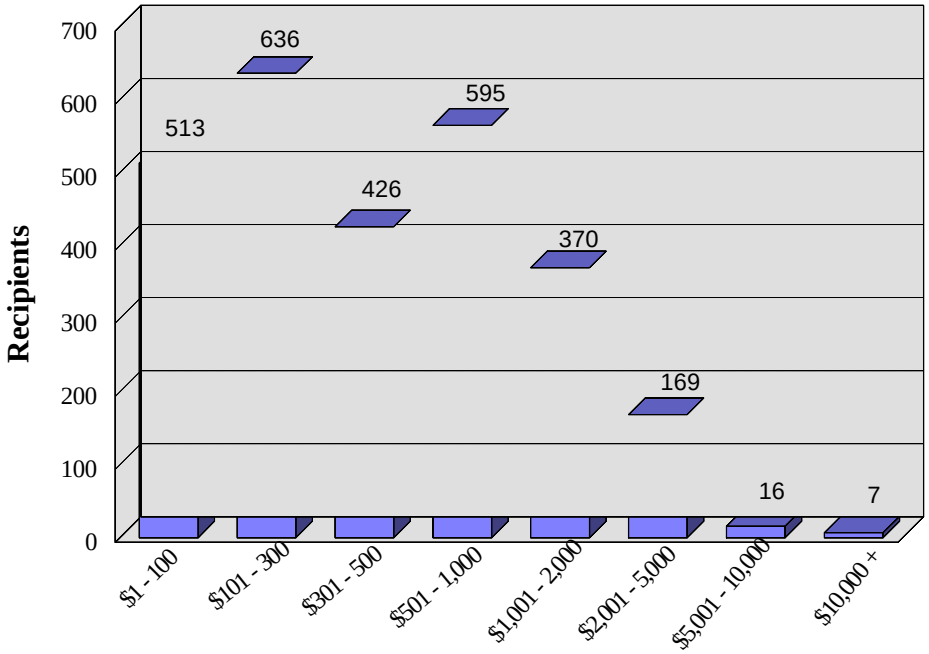
Data from Ist quarter of Fiscal 2004

Figure 3
Services Received by MHSP Recipients



Data from 1st quarter Fiscal 2004

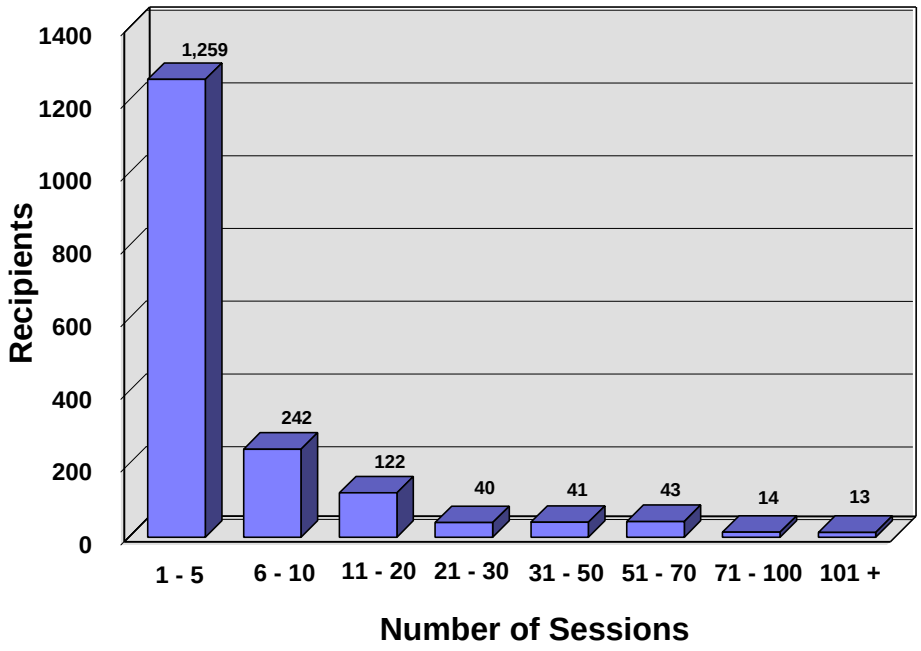
Figure 4
Cost Per Recipient



Data from 1st Quarter Fiscal 2004

Figure 5

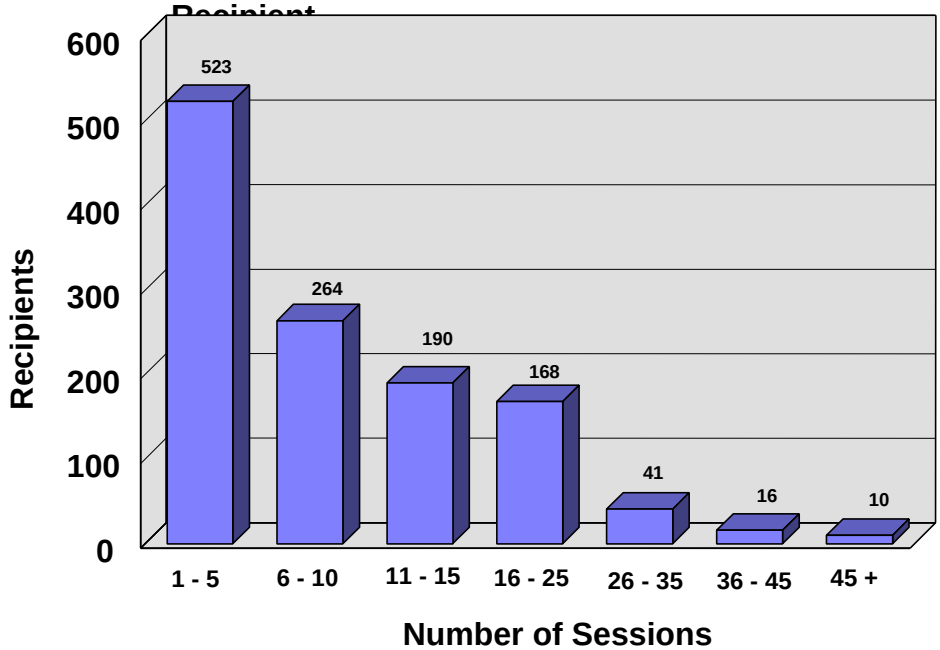
Number of Treatment Sessions Per Recipient



Data from 1st Quarter Fiscal 2004

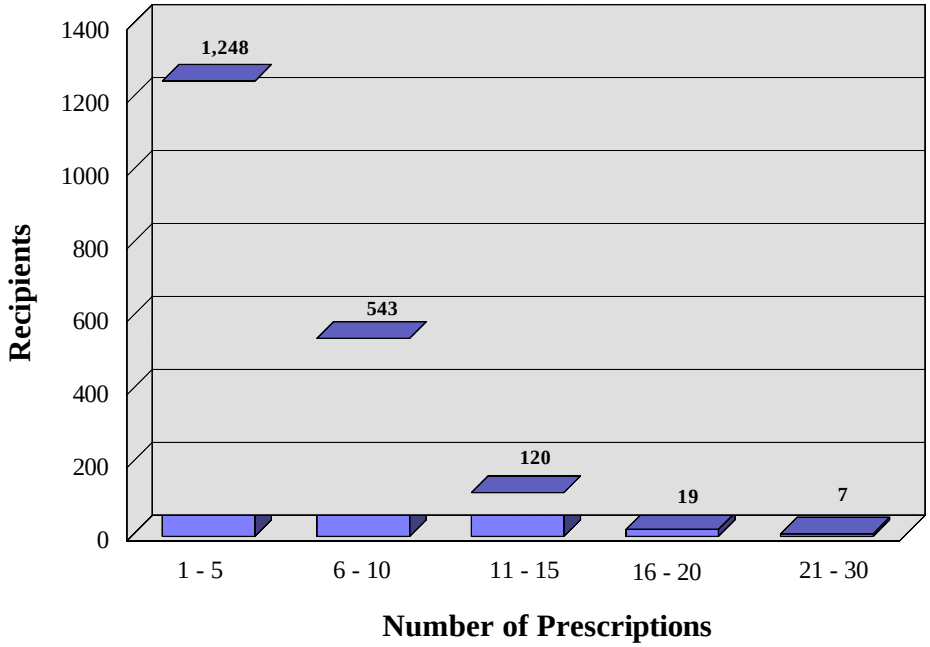
Figure 6

Number of Case Management Sessions Per Recipient



Data from 1st Quarter Fiscal 2004

Figure 7
Number of Prescriptions Per Recipient



Data from 1st Quarter Fiscal 2004